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THE FUNCTION OF THE STATE BUREAU OF MENTAL HYGIENE.

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During the past decade a great deal has been written about mental hygiene, and organizations have been formed with the sole purpose of furthering the principles formulated by the pioneers in this field of endeavor. People are using such words as psychosis, neurosis, and neurasthenia in their daily conversations with little understanding of their significance and the newspapers usually contain descriptions of mental disorders, oftentimes distorted because of the lack of understanding of such matters. Even though the understanding of the real meaning of mental hygiene has not been grasped by the majority of the people, progress is being made in the education of the people and will continue at a much faster rate.

The mental hygiene movement started some years ago in the United States primarily to bring about improved methods in treating the mentally ill, and later included methods to prevent mental illness. In the larger cities there were established clinics under the direction of physicians, especially trained in psychiatry and neurology, who, with the aid of other trained workers, attempted to demonstrate the needs of society in this field of endeavor. At present it may be said that mental hygiene is a branch of medicine which promotes healthful patterns of feeling and thinking, in an effort to prevent subterfuges and substitutions that result in personality changes that are conducive to mental disease. This movement was widespread in its appeal, as people were anxious to learn how to deal with behavior disorders which, in the past, were veiled in mystery and misunderstanding.

In 1928 the State Bureau of Mental Hygiene was established in Richmond to supply the needs of the State and to further the educational programs of medical societies. With the cooperation of physicians of the State of Virginia, demonstration clinics were held in different counties so that the people would gain an insight into the cause of conduct disturbances and treat them properly.

The second important task of the Bureau was to examine all children committed to the Department of Public Welfare from the counties and to act in an advisory capacity as to proper management of these children. This is exceedingly important as each year boys and girls, both white and colored, are committed to the Department because of antisocial conduct, such as stealing, housebreaking, rape, etc., which made it impossible for them to continue to live in the community. Prior to this time these children were punished by being placed in jails; unfortunately, some still are, along with adult delinquents, and while in jail learn habits which they never conquer, such as stealing, lying, sexual perversion, and the like.

Now that we have a better understanding of such disorders of behavior and the relation of adult crimes to the abnormalities occurring in young children, we have a rich field in which to work, offering many rewards, the most important being useful citizens.

An actual case may be used to illustrate the above facts:

John Doe, a white boy, was committed to the Department from a county charged with stealing. He was fifteen years of age when sent to Richmond to be studied in the clinic and had never been away from home before; consequently, he was fearful as to what would happen to him.

Investigation showed that his father died some years ago and his mother was forced to seek employment in a factory. He attended school regularly

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until several years ago but lacked proper clothes and supervision at home and began to play truancy. He associated with an older group of boys, playing about the streets at all hours and soon learned to get show money by stealing. He was easily taken advantage of by the older boys and usually received the blame when any of them were arrested, thus being involved in many crimes. Finally he was sent to Richmond for study, as other methods had failed.

A complete physical examination was made to ascertain any organic disease of the body. It was found that he was markedly under-nourished, anemic, had bad teeth and tonsils. Later a psychological examination was made to determine the intellectual capacity of the patient and revealed that he was slightly below the average for his age, yet capable of doing excellent manual work.

Psychiatric examination was made to determine the patient's failure of adjusting in the community and his type of personality. This examination revealed that he wanted to accept the responsibility of the home but had little confidence in his ability and and there was a marked feeling of insecurity. He was very apprehensive, uncertain of the future and depressed because he had been arrested, feeling that his life was ruined. He was easily influenced by other boys and had lacked the stabilizing influence which his father might have imparted to the home.

At a conference with the State Children's Bureau it was decided to place the patient in a good boarding home in Richmond and have him return to the Mental Hygiene Clinic for psychiatric treatment. He improved rapidly in understanding his particular situation, and became more stabilized emotionally. After several months he was returned home and was able to secure work and thus contributed to the support of the home. Recent reports are encouraging in that he is well liked and trusted by his employer and will be saved from a life of crime.

Another interesting case was referred to the Mental Hygiene Clinic for study about six months ago and received comment in many parts of the country. This boy was sixteen years of age and was arrested for assaulting and shooting at a girl. The family originally came to Virginia from the coal mining section of another state and lived on a small farm on a main highway. Several rough cabins were constructed and the place called a tourist camp. Only a bad element frequented the cabins and there was excessive drinking. The boy's father was a chronic alcoholic, always carrying a gun, and people were afraid of him. The boy was made to drink and was always with his father in any escapades that occurred. Finally, after a fight in the home, the boy shot and killed his father. He was acquitted of this as the father was intoxicated at the time and attempted to kill his wife. Later the boy attempted to manage the tourist camp but continued to drink excessively and abuse those in the home. Finally, he attacked a girl of questionable reputation and tried to shoot her, running everyone away from the home.

Physical examination showed the patient to be badly under-nourished and to have an infection of the mouth and diseased tonsils.

Psychological examination revealed the patient to be mentally defective and his intellectual capacity was that of a nine (9) year-old child.

Psychiatric examination was made which showed the patient to be excitable, restless, lacking proper judgment, and there was a marked feeling of persecution. He had little understanding of the seriousness of the crimes he had committed and his conduct was very silly. He threatened other people, stating that if he was not released he would harm others and when he did return home he would drink more than before. His general conduct was antisocial and he tried to imitate the behavior of his father.

From the above it is plain that this boy could not adjust in society and needed a long period of training in order to over-come the bad habits he had formed. His limited intellectual powers required that he be protected and be given proper guidance.

He was placed in the Industrial School where he has made a good record. Later he may be placed in a good substantial home in the country and here do well with a slight amount of help. If such a boy were allowed to go free after simply a period of correctional care, as was advocated in the past in such instances, he would have been a menace to everyone and soon have a long criminal record.

A final case may be briefly discussed to illustrate the fact that serious mental diseases are recognizable in the early stages.

A white boy, nine years of age, was committed to the Department of Public Welfare on the charge of stealing, house-breaking, and running away from

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home. Since his father's death five years ago the patient has been difficult to manage. The mother had to seek employment in order to support the home, which necessitated her being away from the home all day. Later the patient was placed with an aunt but was not satisfied there and did everything possible to antagonize everyone in the home.

Examination made when he came to Richmond showed him to be a well-developed boy in good physical condition.

Psychological examination showed the patient's intellectual ability or mental capacity to be average for a boy his age.

Psychiatric examination showed that he had a vivid imagination, talked constantly, usually about stealing and pistols, in which he had a marked interest. He was restless, bragging about his strength, and that everyone was against him.

At this time it was recognized that he needed treatment in a mental hospital, but, since there was no institution in the state for boys of his age, he was placed in a foster home where he could be seen frequently by the psychiatrist for treatment. In spite of this he was always causing trouble and was difficult to control.

Finally, after three years his condition gradually became worse and as he developed physically he became more dangerous. He attempted to injure others and had violent outbursts of temper. He was placed in the University of Virginia Hospital but while there attempted to kill another patient on the ward and cut himself with a knife. He was demanding, sullen, and the idea that everyone was against him became more fixed. As a last resort he was placed in one of the State Hospitals where he could be controlled properly over a long period of time and receive the necessary treatment. He improved and was able to help about the office of one of the physicians, which delighted him very much.

If this patient had been allowed to continued at home in the hope that he would outgrow these violent temper outbursts, he would have caused untold trouble and damage to others, to say nothing of the suffering he would have endured.

From the above cases, chosen at random, the function of the Bureau of Mental Hygiene and the Mental Hygiene Clinic is illustrated. The staff now consists of a director-psychiatrist, psychologist, pediatrician, nurse, and clerical workers. By working in cooperation with the State Children's Bureau proper placement of patients studied can be arranged and return to society facilitated.

During the past year about 1,100 cases were examined in the clinic, the ages ranging from eight to eighteen, the average being fourteen years for those committed to the Department of Public Welfare. Adult cases and children not committed to the Department are accepted for study when referred by a physician or some reliable social agency and recommendations made as to proper solution of the problem at hand.

It is the hope of the Bureau of Mental Hygiene that its services may be further extended so that more intensive study will be possible, but this is dependent upon the education of the public of the State so that the importance of such work will be understood. Certainly such work would save the State money, as many people could be saved from mental and criminal institutions in which millions of dollars are spent each year.

1016 E. Clay Street.

TREATMENT OF FRACTURES OF THE HIP BY USE OF THE SMITH-PETERSEN PIN.

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Within the last few years many improvements have been made in handling fractures of the neck of the femur, called by Kellogg Speed "The Unsolved Fracture." In this article we are giving a brief review of our method of treating fractures through the femoral neck and trochanters of the femur.

No method of treating these fractures is of value without reduction. Whitman taught us the method of reduction, and to him goes credit for the first real advance in handling this particular fracture.

Many pins, wires, nails and bone pegs have been used on fractures of the hip, but to Smith-Petersen

goes credit for bringing out the flanged pin. The use of this pin cannot be considered the only method of treatment because the amount of vitality required for the patient to go through this operation is not always present, particularly in patients of advanced age, yet the Smith-Petersen pin has marked a real advance in the handling of hip fractures.

Johansson, in January, 1932, reported on nine operations in which Smith-Petersen's flanged nail was used, with the small hip incision. Wescott, working independently of Johansson, in February, 1932, developed his operation for insertion of the Smith-Petersen pin, with the small hip incision, and in July, of the same year, published his results on three cases.

In this article twelve cases treated in 1935 are reported.

In nine of these cases the injuries were sustained when the patients fell; in one case a push car wrecked, threw the patient off and his right hip struck a cross-tie; in one case the patient was standing on the carriage of a crane, and another crane knocked him twenty-five feet to the ground; another patient was injured in an automobile accident.

The ages of these patients ranged from eighteen to eighty-eight years, three being in the sixties, three in the seventies, and two in the eighties. Eight were females and four were males. One of these patients died the day following operation due to an acute dilatation of the heart. Two were operated

a b c

Fig. I.—Case I. M. Age 34.
a. Intra-trochanteric fracture of femur.
b. Under local anesthesia fracture reduced and Smith-Petersen pin inserted, lateral view.
c. Antero-posterior view.

a b c

Fig. I.—Case II. F. Age 64.
a. Trans-cervical fracture, neck of femur.
b. Under local anesthesia reduction was made and Smith-Petersen pin partially inserted.
c. Completion of insertion of pin.

on at a hospital in another town. On an average, the patients treated at the Lewis-Gale Hospital were up in a chair five and one-half days after operation, walked on crutches twenty days after operation, and were dismissed from the hospital twenty-nine days after operation.

a b c

Fig. I.—Case III. F. Age 62.
a. Fracture, femoral neck of femur with marked angulation.
b. Under local anesthesia reduction was made and Smith-Petersen pin inserted, antero-posterior view.
c. Lateral view.

Six of these operations, including reduction, were done under local anesthesia; the others were started under local anesthesia, and a small amount of nitrous oxide with oxygen was administered. Local anesthesia is preferred in these cases because there is not as much danger to the patient and, except for jarring the hip, which produces more fear than actual pain, the patient dozes during the operation. Since most of them are old and feeble, it is desirable to avoid a general anesthetic if possible. An operative procedure that is not serious in a young, healthy person becomes a major consideration in the old and feeble.

In each case the pre-operative treatment has been about the same. Patients are given three grains of sodium amytal six hours before operation, three grains two hours before operation, if the patient is not drowsy, and one-sixth grain of morphine hypodermically immediately before operation.

Two points should be kept in mind at all times: First, reduction; second, correct insertion of the pin. In these cases no type of angle or score sheets have been used to determine the position.

a b

Fig. I.—Case IV. M. Age 18.
a. Trans-cervical fracture, neck of femur. Fracture reduced, pin partially inserted.
b. Insertion of pin completed, antero-posterior view.

These operations are done on the fluoroscopic table under novocain anesthesia, with the addition of nitrous oxide with oxygen when necessary, a three- to five-inch incision being made at the base of the trochanter of the hip. The method of insert-

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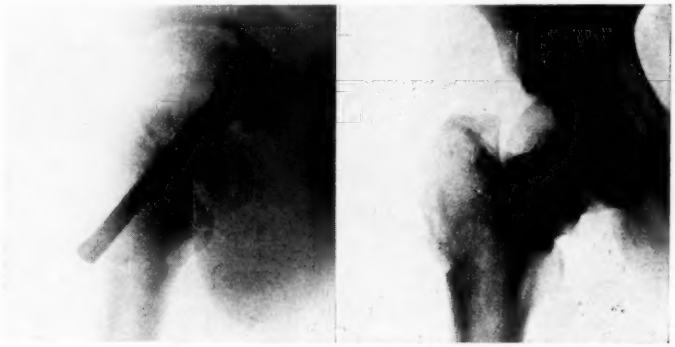
ing the pin is as follows: After the edges of the wound are separated it is borne in mind that the line of direction from the trochanter to the head of the femur is forward. We know that a pin placed at the base of the trochanter is correct as to the upper and lower position. To get the pin into the center position from an anterior and posterior viewpoint, a hemostat, or other instrument, is placed on the upper portion of the femur, another is placed on the inferior portion of the femur, and the pin, inserted midway between these two instruments, should go in as nearly in the center line as any angle measurement could determine. With the pin held in place by a pair of pliers, or by the hand, we look through the fluoroscope and get the upward direction; then, keeping in mind that the head of the femur is forward, the pin is driven in. This year we are using an instrument invented by Dr. J. Warren White, of Greenville, South Carolina. This instrument is screwed into the head of the Smith-Petersen pin and eliminates the use of pliers. We have found this highly satisfactory. After the pin is in one inch we look through the fluoroscope and, if the position appears to be good, the pin is driven in another inch. Then the operative field is covered with sterile towels and stereoscopic X-ray films are made. If these show the position to be correct, the pin is driven in within one-half inch of its entire length, after which we look through the fluoroscope, only as a safety measure because the length of the pin has previously been determined, and in each case there has been sufficient distance left to carry the pin in its full length. It has been found very simple, as a rule, to insert the Smith-Petersen pin.



a b

Fig. II.—Case IV.
a. Smith-Petersen pin inserted, lateral view.
b. Pin removed. Complete solid union of fracture.

a b

Fig. I.—Case V. F. Age 79.
a. Trans-cervical fracture, base of neck of femur; marked angulation.
b. Fracture reduced, Smith-Petersen pin inserted.

The length of the pin is determined by compari-

son with a metallic measuring rod of known length, which is placed vertically on the outside of the uninjured hip, as nearly opposite the center of the upper end of the shaft of the neck of the femur as possible. Films are then taken and the length from the base of the trochanter to the head of the uninjured femur is estimated, making comparison with the length of the known measuring rod.

The entire operation, using novocain anesthesia, and waiting for the development of one set of films, requires from twenty-five to forty-five minutes. The position of the pin has been good in each of the cases treated, no withdrawal of pin has been necessary and there has been no shock or appreciable elevation of pulse. In the cases in which we have used the Smith-Petersen pin, there have been no infections or other complications.

A point well worth noting is that some form of traction is usually used for several days prior to operation. If traction is used for three or four days to relax the muscles before the Smith-Petersen pin is inserted it gives the patient time to recover from the shock of the injury, and Nature time to wall off the fracture area to a certain extent, reducing the chances of infection. Reduction is made less difficult and there is a better possibility of completing the operation under local anesthesia.

It is not felt that this pin is a panacea for fractured hips because of two cases that have come under our observation, one a case operated on by a well-known surgeon, in which there has been absorption for at least one inch of the neck of the femur, and at present there is a two-inch shortening of the limb. This case, however, was not referred to the surgeon until more than a year after the fracture occurred.

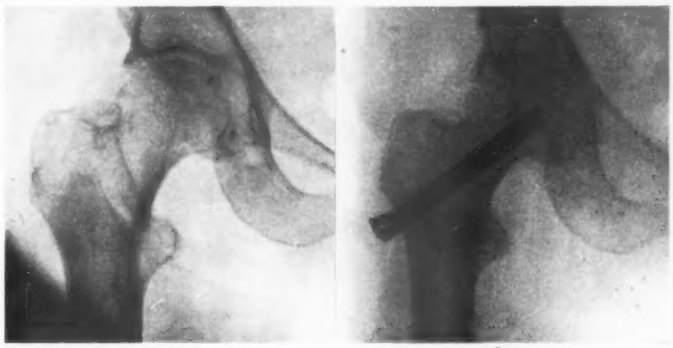


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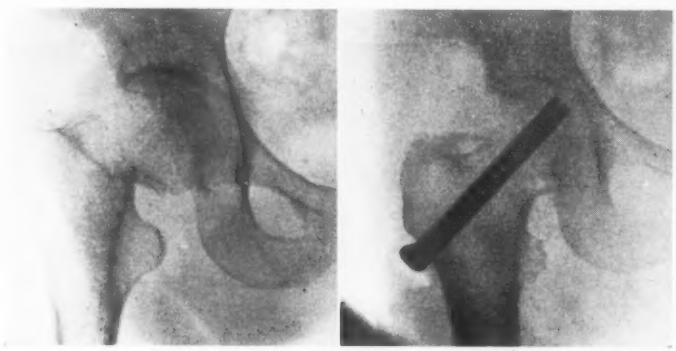
Fig. I.—Case VI. F. Age 79.
a. Trans-cervical fracture, neck of femur.
b. Under local anesthesia fracture reduced and Smith-Petersen pin inserted.



a b

Fig. I.—Case VII. F. Age 88.
a. Trans-cervical fracture, neck of femur.
b. Under local anesthesia fracture reduced and Smith-Petersen pin inserted.

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If the only good found in this operation were that it enables the patient to get out of bed in four or five days, or earlier, then the operation would not stand, because with a Roger Anderson well-leg splint patients can be allowed out of bed just as quickly. In our series of fractures of the neck of the femur there were three cases that were treated entirely by the Roger Anderson well-leg splint, with perfect reduction and good end results,—that is, good union, no shortening, no ankylosis, and no pain upon walking after union had occurred.

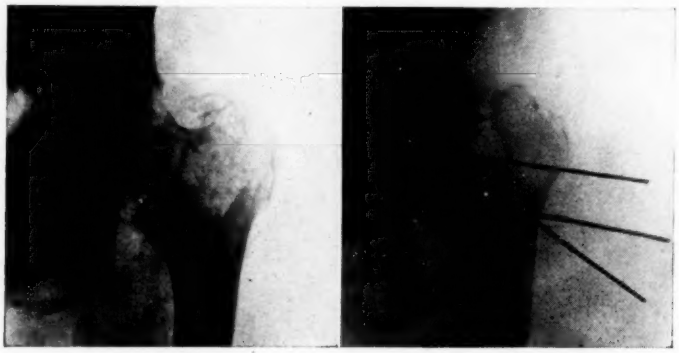

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Fig. I.—Case VIII. F. Age 76.
a. Intra-trochanteric fracture, neck of femur. Patient had extensive cardiac disease.
b. Smith-Petersen pin not attempted because patient had myocarditis and a stroke of apoplexy two months previously. Condition was very poor. Fracture reduced under local anesthesia and held in place by three Kirschner wires. Patient died, cardiac death, about six weeks after wires were inserted.

A satisfactory explanation of non-union cannot be given, but in the opinion of the writer the one dominant factor is blood supply. The poor blood supply in the region of the hip has been repeatedly mentioned as the cause of non-union, yet the fact remains that there was sufficient blood supply before injury, and the real change that occurs after injury is inactivity. The conclusion naturally drawn is that blood supply depends upon activity. With the Roger Anderson well-leg splint there is activity and resulting good blood supply. With the Smith-Petersen pin, after the first few days there is even more activity, and a return to normalcy of circulation, and therein lies the secret of the good results obtained with the use of this pin. Normal blood supply in all fractures marks the difference between quick union and delayed union, or non-union. All other things being equal this is the rule, and the rule depends upon good reduction, no interposing soft tissues, and no change in general health.

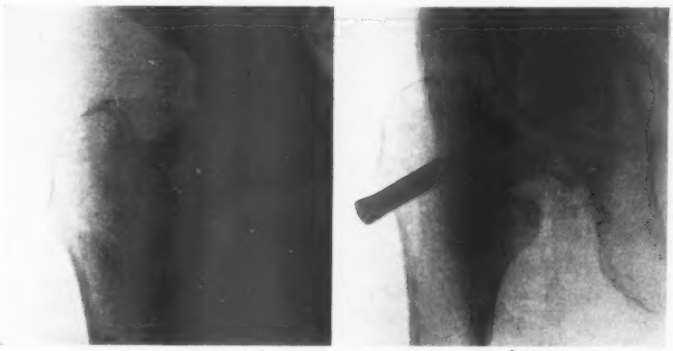
a b

Fig. I.—Case IX. F. Age 50.
a. Intra-trochanteric fracture of femur.
b. Smith-Petersen pin inserted.

With the permission of Dr. Kellogg Speed and

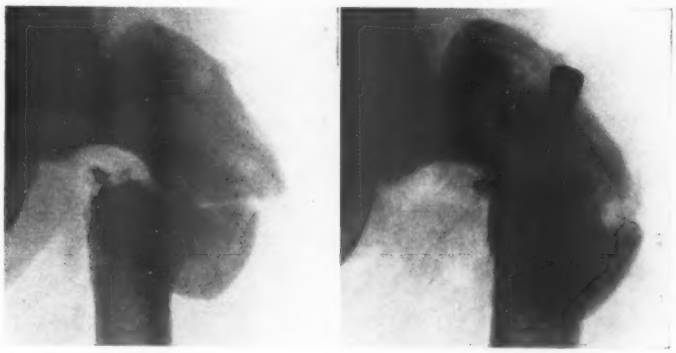
a b c

Fig. I.—Case X. F. Age 78.
a. Intra-trochanteric fracture, neck of femur with angulation.
b. Fracture reduced, Smith-Petersen pin inserted. Bone extremely brittle and friable.
c. Second Smith-Petersen pin introduced. Patient died, cardiac death, about seventeen hours after pin was inserted.



a b

Fig. I.—Case XI. M. Age 84.
a. Intra-trochanteric fracture of femur with angulation.
b. Under local anesthesia fracture reduced and Smith-Petersen pin inserted.



a b

Fig. I.—Case XII. F. Age 66.
a. Patient had an old healed fracture three years ago of neck and trochanters of femur with marked angulation, excess callus and deformity present. She slipped on rug, fracturing shaft of femur through the old fracture, the distal fragment being displayed upward, inward and mesially.
b. Fracture reduced and Smith-Petersen pin driven vertically downward through trochanters and shaft of femur.

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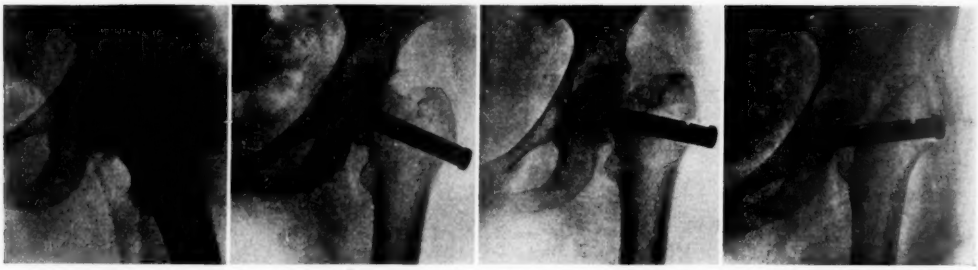
DR. SPEED'S CASE.



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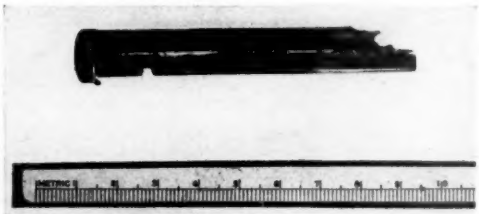

e

Case No. 000, Fig. I. "a, Repair of fracture of neck in a woman fifty-three years old, by means of the Smith-Petersen nail. The fracture occurred August 21, 1932; nail was inserted August 24, 1932. From the service of Dr. Phemister at the University of Chicago Clinics. b, Same patient. This film taken when plaster was removed on October 26, 1932. Apposition, angle of neck and penetration of nail all very good. Head appears slightly denser than surrounding bone with well-rounded outline and not spotty. Prognosis good. c, Same hip February 17, 1933. Patient had never worn a caliper but had used crutches and not borne full weight. Much pain. The head appears aseptically necrotic in upper portion; some effort at bone replacement in the lower half which is of less density. Union, however, has not been obtained. The trochanteric portion of the bone has slipped up, the neck is depressed and the nail, strange to say, shows evidence of absorption in a notch-like area near its head and a little roughening at its extremity. It maintains its long axis but one wonders whether or not the head of the femur may not have rotated on it. This is nearly six months after operation. d, The same hip May 2, 1934. Further dead head and absorption of neck. Increased absorption of the nail, elevation of the trochanter, non-union to a dead head. e, Nail removed from patient. Its absorption and partial disappearance affect its stability as a fixation agent to a certain extent. If the circulation in the head has been so poor that death of it resulted, was change in nail caused solely by mechanical stress, or by action of cells or chemical agents in blood serum? Lowering of blood supply after fracture in the head in living human may not be so great as we suspect." (*Speed*, in *Surgery, Gyn. and Obstet.*)

of the publishers of *Surgery, Gynecology and Obstetrics*, illustrations are shown of Case No. 000, Fig. I (a, b, c, d and e), operated on by Dr. Speed, whose article on "The Unsolved Fracture" appeared in *Surgery, Gynecology and Obstetrics*, February 15, 1935, to show that the Smith-Petersen pin cannot be considered as 100 per cent perfect in these cases, although in our opinion it is the nearest to an ideal treatment that has yet been developed.

The illustrations shown in this article demonstrate the method of treatment.

The twelve cases treated in 1935 are reported here in order that our conclusions may be added to those of other men doing this work. The work of a number of men stands out prominently when fractures of the hip are considered, Whitman for teaching us the method of reduction, Smith-Petersen for inventing the flanged nail, Johansson for the small hip incision, and later in the same year Wescott, working independently of Johansson, also used the small hip incision. Others have added instruments which have made the handling of these hip cases simpler.

In this series of cases there has been only one death. We feel very certain that with the old method of treatment there would have been many more deaths. It is also felt the end results in the patients treated by using the Smith-Petersen nail with the small hip incision, have been so much better than the end results obtained by treatment by the old method, that they are hardly comparable.

We still consider other methods of treatment, but usually decide in favor of the small hip incision with the use of the Smith-Petersen nail.

EXTENSIVE VESICO-VAGINAL FISTULA WITH URETERO-INTESTINAL ANASTOMOSIS—CASE REPORT.*

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and
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Fistula of the genito-urinary tract in the female has been known to occur since the Middle Ages and numerous reports of this condition have been recorded in the medical literature. There is no lesion to which the female is subject that is more distressing than a vesical fistula, especially one large enough to permit constant drainage of urine through the vagina. The resulting discomfort, odor and pain relegated these patients to a life of misery and solitude until the epoch-making work of Sims, Emmet, Simon and their contemporaries restored these people to a useful and tolerable life.

Because of the extensiveness of the fistula and the inoperability by one of the many vaginal methods, necessitating a uretero-intestinal anastomosis, this case was deemed worthy of report with some discussion of the operative treatment. No attempt will be made to discuss the different types of genital fistulas and the numerous methods of repair. For an extensive historical review of the subject, the reader is referred to the recent article, entitled "Treatment of Vesico-Vaginal Fistulas—Past and Present," by Norman F. Miller in the *American Journal of Obstetrics and Gynecology* for November, 1935.

Pathology.—Three types of fistulas may occur: the vesico-vaginal, the vesico-cervico-vaginal, and the vesico-uterine. The vesico-vaginal is by far the most common and our discussion will be limited to that type. The fistula may vary in size from that of a pin-point to the complete destruction of the bladder base and floor of the urethra, which is well illustrated by our case. The usual lesion found is a fistulous tract or opening of ½ to 1½ cm. in size, connecting the anterior vaginal wall with the bladder base in the region of the trigone.

Etiology.—Genital fistulas result (1) from trauma, either obstetrical or surgical, (2) from necrosis or ulceration by disease processes, or (3) from congenital malformation. The most common causes are *birth trauma, operations* and *necrosis,* and some emphasis should be given these etiological agents

(A) *Birth Trauma:* Rupture of the base of the bladder with resulting vesical fistula may follow forceps delivery, embryotomy, craniotomy, bag induction, version and extraction or any of the operative obstetrical procedures. It may result from failure of obstetrical lacerations to heal after the primary repair. Necrosis of the tissue may result from prolonged pressure on the soft parts, as pressure of the presenting part in an abnormally long labor, with ischemia and necrosis of the vaginal wall and bladder base.

(B) *Operations:* Of the operations, radical hysterectomy for malignant lesions of the uterus and cervix is the most frequent cause, although it occasionally follows the repair of cystocele in which healing does not occur.

(C) *Necrosis:* Carcinoma of the cervix or uterus may invade the bladder and ultimately result in a vesical fistula. Since the more widespread use of radiation therapy in pelvic malignancy, necrosis following the use of radium or radon needles is not an uncommon cause of vesical fistula.

Emmet, one of the pioneers in the field of surgical repair of genital fistulas, reported that during the twenty years, 1855-1875, there were 346 cases of vesico-vaginal and recto-vaginal fistula treated at the Woman's Hospital and he gave details of 202 personal cases treated. Of his cases, 171 or 84.6 per cent were due to obstetrical injury, and he believed that vesico-vaginal fistulas are due to delay in delivery after impaction of the presenting part has taken place, with resulting ischemia and necrosis of the tissues. In comparing these figures with those cases fifty years later at the Woman's Hospital from 1916-1925, eighty-six cases of vesico-vaginal and recto-vaginal were encountered, with 32 or 40 per cent due to obstetrical injury.

Frank reports nineteen urinary fistulas at the Mt. Sinai Hospital over a period of twelve years, with six (31.5 per cent) due to obstetrical injury. Mack-

*Read before the South Piedmont Medical Society in Lynchburg, Va., April 21, 1936.

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enzie of the Royal Victoria Hospital reported an incidence of 53.8 per cent as due to obstetrical trauma. Judd, at the Mayo Clinic, reported eighty-two cases during the twelve years from 1908-1919 with 32, or 39 per cent, resulting from obstetrical injury.

In analyzing these statistics, we find that the incidence of genital fistula following child-birth has been reduced from 84.6 per cent to between 32-53 per cent. This is due to a general improvement of the practice of obstetrics, with a better knowledge of forceps delivery and other operative obstetrical procedures. The apparent increase following surgery is due to a general increase in the number of pelvic and abdominal operations. A general increase in the use of radium for pelvic malignancy has also increased the incidence of fistula, other than that following child-birth. In 1925, Ward and Farrar reported an incidence of 6 per cent of genital fistula following the use of radium in 196 cases of carcinoma of the cervix.

Symptoms: When the fistulas are very small, there may be no symptoms other than intermittent leakage of urine through the vagina, with a feeling of moisture of the genitalia. In large fistulas with a constant leakage of urine from the bladder, the vagina and external genitalia are constantly bathed in urine, resulting in excoriation of the mucous membrane and skin. This gives rise to constant pain, burning and irritation and the odor of the urine becomes very offensive. There is also usually an associated cystitis, often of an encrustating type, with the usual symptoms and discomfort. In many cases, this constant source of pain and discomfort may lead to serious nervous manifestations in the patient.

Diagnosis: In large fistulas, the diagnosis is obvious on inspection of the anterior vaginal wall. In minute fistulas, the diagnosis is sometimes difficult, if surrounding edema closes the opening. Cystoscopic examination often confirms a doubtful diagnosis. In most cases, the injection into the bladder of a colored solution, such as 1 per cent mercurochrome solution, methylene blue, or indigo carmine, will reveal an opening on the anterior vaginal wall as the colored solution drains through the bladder.

Treatment: The treatment of vesico-vaginal fistula is *operative closure,* but many factors enter into the plan of treatment, namely: (1) the age and general condition of the patient, (2) the location of the fistula, (3) the condition of the surrounding tissues, and especially, (4) *the size of the opening.*

The essential principles governing the operative treatment remain those laid down by Sims more than fifty years ago, namely: (1) *restoration of healthy tissue in the operative field before repair is attempted,* (2) *adequate exposure of the operative field at the time of closure, and* (3) *closure of the wound edges without tension.* As a general rule, no vesico-vaginal fistula should be operated upon less than two months after the occurrence, especially if it results from obstetrical injury, as involution of the tissues and spontaneous healing often occurs.

Pre-Operative Preparation: General preparation of the patient for operation consists of improving the general health of the patient by proper rest, diet, cleanliness, treatment of anemia, etc. Preparation of the operative site consists of giving warm boric acid, sodium bicarbonate or weak antiseptic douches, daily bladder irrigations with saturated solution of boric acid, 1:2000 solution of potassium permanganate or acriflavine, followed by bladder instillation of 10-20 per cent argyrol solution or 2-4 per cent mercurochrome. Local applications of 10 per cent silver nitrate to the edges of the fistula may help the local healing process. Urinary antiseptics by mouth, such as urotropin, acriflavine, pyridium, etc., and an adequate fluid intake help to improve the urinary infection and complicating cystitis.

Operative Closure: Each case must be individualized as to operation. The location of the fistula, and especially the size of the defect are the cardinal points in selecting an operative approach. In most cases, repair of the fistula through the vagina is preferable, although some men prefer the suprapubic approach through the bladder in some cases.

After securing the proper exposure, either by the Sim's, Bozeman's (knee-chest) or lithotomy position, the usual method of repair consists of adequate mobilization of the bladder and vaginal wall to secure closure without tension. The dissection is begun well back in the healthy tissue of the vaginal mucosa, around the opening, extending down to the bladder mucosa. The vaginal wall and bladder are separated by blunt dissection and the opening closed by small chromic catgut sutures. The vesico-vaginal fascia and vaginal mucosa are then closed in layers. The classic operation of Sims consisted of merely dissecting the edges of the fistula with scissors and closure of the opening by interrupted sutures of

silver wire, but the use of silver wire is no longer popular. Silk, silkworm gut or catgut are now used principally as sutures. Following closure of the fistula, drainage of the bladder through a retention catheter is not necessary, but is advisable for three to five days. Placing the patient on her abdomen hastens the healing process, according to Miller. Following operation, the vaginal hygiene, daily bladder irrigations and instillations should be continued as in the pre-operative treatment.

Although this general plan of operative treatment is adequate for most cases, extensive vesico-vaginal fistulas, with loss of a large amount of tissue, are difficult to repair by the usual method of vaginal closure, and it is this type of case which is best treated by an intra-peritoneal transplantation of the ureters into the sigmoid colon after the method devised by Coffey, with or without the later removal of the bladder. A very large vesico-vaginal fistula with extensive tissue destruction is represented by our case, a brief report of which follows.

CASE REPORT

N. E., a colored multipara, age forty-two years, gravida nine, was admitted to the hospital on June 28th in a condition of shock and exhaustion. She had previously had eight full-term deliveries without complication. She had been in active labor for four days and nights preceding admission and was under the care of a midwife, who had made repeated attempts to deliver the child without success. Examination showed the patient to have a full-term pregnancy with a large child presenting by breech in the R. S. P. position. The cervix was fully dilated and effaced and the breech was deeply and firmly engaged in the pelvis. Her temperature was 97.4, pulse weak and thready, blood pressure 80/? and the patient very weakened and exhausted in appearance. Abdominal examination revealed a tense, tender abdomen with the uterus rigid and tetanic. No fetal heart tones could be heard, and no movements seen. After preliminary supportive treatment and the administration of pantopon and amytal, the patient was prepared for delivery and the bladder catheterized. The urine obtained showed macroscopic blood, confirmed by microscopic examination. Without further anesthesia, the frank breech presentation was broken up, a foot delivered, and the delivery of a macerated stillborn, full-term child completed without difficulty, no instrumentation being necessary. The condition of the patient was grave immediately after delivery but she responded well to the administration of glucose and normal saline intravenously, cardiac stimulants, the application of heat, and a blood transfusion.

In view of the prolonged labor with the finding of gross blood in the bladder on admission, injury to the bladder was suspected. On the second post-partum day, the gross leakage of urine through the vagina was visible. The patient ran a very stormy, febrile course with a daily temperature of 101 to 103 degrees for two weeks, with a very foul lochia, and urine draining constantly from the vagina. On the twelfth day post-partum, vaginal speculum examination with the instillation of methylene blue solution into the bladder, revealed a large opening from the bladder into the vagina. The entire base of the bladder and the vault of the vagina showed an extensive necrotic slough, and the inflammatory reaction was so marked that the extent of the fistula could not be accurately determined. Treatment was continued, consisting of repeated blood transfusions, forcing fluids, anti-anemia diet, iron by mouth, urinary antiseptics and bland douches, with bladder irrigations and instillations, and postural drainage. The patient was discharged from the hospital on the thirty-first day post-partum, and advised to return to the hospital in two months for examination and operation.

The patient returned to the hospital on October 18, 1935, fourteen weeks after delivery. Pelvic examination at this time showed a large vesico-vaginal fistula through the anterior wall of the vagina. This fistula was about 5 cm. long and 2½-3 cm. wide with a large portion of the bladder base and anterior wall missing. On insertion of vaginal speculum, the orifices of both ureters were readily visible through the opening and could be catheterized easily. The edge of the fistula and surrounding vaginal mucosa was inflamed and there was a constant leakage of urine through the vagina. At this time, the general condition of the patient seemed very good, except for excessive dryness of the skin. Hb. was 70 per cent; R.B.C. 3,420,000; W.B.C. 6,500. Pre-operative care consisted of daily douches, nourishing diet, bed rest, soda baths. The N.P.N was 33.6 on November 1, 1935. On November 5th, under general anesthesia, the right ureter was dissected free, divided about three inches above the bladder entrance and was transplanted into the sigmoid colon

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after the method of Coffey, using interrupted sutures of catgut. The patient stood the operation fairly well and reacted promptly. The usual post-operative treatment consisting of intravenous fluids, sedatives, nothing by mouth, etc., was instituted. The following day the temperature rose to 103.4 with a pulse rate of 120. She continued to show an elevated temperature daily for the first twelve days post-operative. Two days after operation the N.P.N. was fifty-four, the fourth day eighty, and on the seventh day was fifty-seven mgm./100 c.c. The rectal tube began to drain uriniferous material about the fourth day. Progress was excellent until the seventh day post-operative when temperature again rose and patient had two chills. The following A. M., there was a well-developed parotitis on the left side with extreme tenderness. This condition gradually subsided under treatment, the temperature returned to normal and the operative incision healed nicely. On December 2nd, under general anesthesia, the left ureter was transplanted into the sigmoid about two inches above the site of the right ureteral anastomosis, and the patient stood this operation quite well. The day following operation, a blood transfusion was given. The temperature rose to 104.8, with a pulse rate of 132, although the patient's general condition remained fairly good. There was very little abdominal distention, no nausea and no vomiting. The daily N.P.N. showed a rise from 63.8 the day following operation to 133 on the eighth day, and then remained around 100-105 mgm. during the remainder of her stay in the hospital. The second operative incision healed nicely, and urine ceased to drain through the vagina. The patient manifested very good bowel control, going about two to three hours between passage of urine from the bowel. The patient remained in the hospital for a period of about six weeks following the second operation, and during this time was allowed up gradually. The application of walking casts was necessary before she could walk, due to muscular atrophy and weakness of the legs, which had previously appeared about one week following delivery. Orthopedic consultation failed to reveal any definite cause for the marked weakness of the legs. The patient was discharged from the hospital on January 16, 1936, in very good condition. She was not seen again after leaving the hospital, and death occurred about April 6th, three months after discharge, and four and one-half months after the last operation. The cause of death was not determined, although a progressive uremia is very likely.

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Allied Arts Building.

TUBERCULOSIS EDUCATION—HOW FAR HAVE WE PROGRESSED?

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In March, of 1936, the tuberculosis seal sale committee of Isle of Wight County requested the Director of the Isle of Wight-Nansemond-Suffolk Health Department to give tuberculin tests to all members of the senior class in the four white high schools of the county whose parents would consent to same. Accordingly, a letter of explanation and a permission slip were prepared and given to each member

of the senior class to take home to his parents. Before doing this, however, the county superintendent of schools, the principals of the individual schools, and the physician members of the Board of Education were consulted and their permission and cooperation obtained. The result is as follows:

School	*Enrollment*	*Number taking test*	*Number positive*	*Number negative*
Smithfield	38	18	10	8
Isle of Wight C. H.	14	10	5	5
Windsor	16	10	3	7
Carrsville	13	10	3	7
Total	81	48	21	27

It is worthy of note that of eighty-one children enrolled only forty-eight took the test. Three of the schools responded quite well and the Windsor school even better than the figures indicate, as some of these children were absent, due to illness, at the time we administered the test.

This activity was conducted just prior to a tuberculosis and X-ray clinic held at Smithfield under the auspices of the State Department of Health. Of the twenty-one children showing positive reaction fourteen visited the clinic with the following results:

School	*Total tuberculin postive visiting clinic*	*Total showing active tuberculosis*	*Total showing calcium deposit*	*Total showing no disease*
Smithfield	6	1	4	1
Isle of Wight C. H.	3	0	3	0
Windsor	3	0	1	2
Carrsville	2	0	2	0
Total	14	1	10	3

Each senior showing a positive reaction who did not attend the clinic was interviewed, and a separate visit made to the parents to ascertain if the reasons given would correlate. Below are the results:

PUPIL	PARENT
1. W., F., 17. Influenced by mother's lack of interest.	1. Mother had not a clear idea as to why test was to be given.
2. W., F., 17, and W., F., 18. One did not believe anything was wrong. The other made no comment.	2. Lack of funds for X-ray, but willing for girls to have physical examination.
3. W., F., 17. Did not want to take test.	3. Guardian glad for chance for examination. Child indifferent.
4. W., F., 17. Did not want to be embarrassed preparing for examination.	4. Mother insisted the child attend, but father indifferent.
5. W., F., 17. Family doctor requested home not be visited.	5. House not visited at request of family doctor.
6. W., F., 17. Prefer family doctor take X-ray.	6. Prefer family doctor.

It is to be observed that No. 2 relates to two girls, sisters, which accounts for six interviews totaling seven children.

It might be well to state that before the clinic was held the endorsement of all physicians was obtained, and no person was accepted unless he had a permission slip signed by the family doctor.

The disparity in some instances between the explanations given by the pupils and that of the parents is quite noticeable, as in two, three, and four.

The thirty-three seniors who did not take the tuberculin test were also visited, as well as their parents, to ascertain the degree of agreement in statements. (See Table on page 410.)

Of the twenty-one seniors showing positive tuberculin reaction, twenty were called on before the clinic was held and urged to attend. One who did not attend was not visited as the family physician considered it inadvisable.

Of the twenty-one positive seniors the Health Department had information on eight as having been in intimate contact with cases of tuberculosis, and of the twenty-seven showing a negative reaction the Health Department had information on six as having been in contact with positive cases.

THE NECESSITY FOR TAKING ADEQUATE TIME IN INTERVIEWING PERSONS

It is interesting to study the following, particularly from an educational point of view, as well as to show the necessity of expending an adequate amount of time, to obtain the real reasons that motivate a pupil in not taking the test or coming to a clinic after a positive reaction has been obtained. We have in mind a W., F., 21, living with her father, the mother having died of tuberculosis sev-

eral years previously. When speaking with the father, as we had been told he was objecting to the girl's coming to the clinic, we were informed that it was not a question of the cost of the X-ray, but that his wife had seven doctors, none of whom could do anything to remedy her condition, and therefore he considered any effort with the child as futile. After a conversation on tuberculosis and other subjects that lasted about three-quarters of an hour, he stated that it was all right if the girl cared to go.

SENIORS NOT TAKING TUBERCULIN TEST

PUPIL	PARENT
1. Nine pupils—"I do not want to take it."	1a. W., M., 16,—"I did not insist—might make him sick." b. W., M., 18,—"I (father) did not know what test was for, his mother did not insist." c. W., M., 17,—"Child told us (parents) he was going to take the test." d. W., M., 17,—"We (parents) did not know of the test until after it was given." e. W., M., 17,—"I (mother) wanted him to take the test." f. W., M., 17,—"We (parents) did not know of the test." g. W., M., 16,—"We (parents) did not know of the test." h. W., M., 16,—"We (parents) were willing but did not know of the test as the boy was away from home." i. W., M., 16. Were not interested.
2. Four pupils—"I do not want needle in my arm."	2a. W., M., 16. Does not approve of clinics. b. W., M., 18. Cooperative but did not insist. c. W., M., 16,—"I (mother) did not insist. I did not have a very clear idea of the test." d. W., M., 16,—"We (parents) did not insist."
3. Two pupils—"I do not want serum put in my arm."	3a. W., F., 16. Lack of interest. Left it to child b. W., F., 17. Lack of interest. Left it to child.
4. Two pupils—"I consider my health all right and do not want to take the test."	4a. W., F., 16. Lack of interest on part of mother. b. W., F., 16,—"We did not insist."
5. W., F., 16,—"There is no need to take the test."	5. "I (mother) told the child to take the test."
6. Two pupils influenced by mother.	6a. W., M., 18,—"I (mother) consider myself capable of taking care of my children's health." b. W., M., 16. Left it to child.
7. Two prefer family doctor.	7a. W., F., 19. Prefer family doctor. b. W., F., 16. Prefers child not take test.
8. "I had to wrestle that night and was afraid my arm would be sore."	8. "I (mother) signed consent slip."
9. Seven absent due to illness.	9. This is a true statement.
10. W., M., 17. Parents objected.	10. Parents objected.

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Our next step was to consult with the girl in the presence of her father, and then, it seemed to us, the real reason came forward. The girl stated that since her mother's death her father had been her great companion, and if she visited the clinic and an active condition was found she would be advised to go to an institution, which would take her away from her daddy. She was a very sensible girl and was eventually induced to come to the clinic, being told that even if an active condition was found that would not compel her to visit an institution unless she consented to do so.

THE AMOUNT OF EDUCATIONAL EFFORT STILL NEEDED

While the results obtained from our endeavors to induce this set of pupils to have tuberculin tests made were not exactly what could be termed satisfactory as only forty-eight of the eighty-one enrolled submitted, nevertheless it can reasonably be assumed that this is far in excess of what could have been accomplished twenty-five years ago. Then, again, in one school only eighteen of an enrollment of thirty-eight responded, which reduced the percentage materially. The basic fact remains that considerably more time must be spent in bringing the message of tuberculosis prevention and control to both pupil and parents before better results can be obtained.

RESULTS OF CLINIC

Of the forty-eight pupils taking the tuberculin test twenty-one gave a positive reaction, and of these fourteen visited the clinic. One showed active condition of childhood type and ten showed calcium deposits. Three were negative. The active case and four of the ten showing calcium deposits have been placed under the care of physicians. If these calcium deposit cases can be prevented from becoming active our efforts will be well rewarded.

RESULTS OF AFTER CLINIC FOLLOW-UP

The following throws some light on the possibilities involved so far as preventing active disease is concerned:

White, male, 23, who had taken quite an active interest in athletics, intended to become a baseball player, but we explained that it would be more beneficial to maintainence of health if his activities be limited to a vocation requiring less strenuous exertion.

White, female, 17, intended to become a physical instructress, but it was explained that this required an expenditure of energy beyond her physical capacity, and quite reluctantly she agreed with us.

OUR ENDEAVOR FOR THE FUTURE

That more educational efforts are required can hardly be considered controversial, particularly in view of the large numbers that gave as their reasons—

"Do not want to take it;"
"Do not want needle in arm;"
"Do not want serum put in arm;"
"Consider myself all right;"
"Do not want to take test;"
"No need to take test,"

which accounts for eighteen of the thirty-three not taking the test. From the remaining fifteen, seven can be deducted as being out of school on account of illness. It appears that this educational effort is needed more with the pupils than with the parents. Perhaps the reverse would be true if the parents were to take the test.

It shall be our purpose to increase our educational efforts, conducting these activities through all available channels, the schools, the parent teacher's associations, churches, club meetings, etc., and to make a strenuous effort to include the father as well as the mother. This educational campaign will be conducted only with the approval and cooperation of the medical society, and the practicing physicians will make the majority of the talks, as many as arrangements can be made for and they find time available. Pertinent points will be collected and given to all speakers and literature in the language of the people will be distributed. It is our firm belief that health work can only be carried on successfully by having the confidence and cooperation of the practicing physicians, and our relations with the profession are always maintained on a most cordial basis.

We are convinced that such an effort will result in a greater number of seniors of next year's class taking the test and that this piece of work, now in its infancy in this section, will eventually result in preventing many quiescent cases from becoming active. It will likewise redound to the good of the general population in preventing and controlling tuberculosis.

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CANCER OF THE TONGUE—SOME ETIOLOGICAL CONSIDERATIONS—REPORT OF CASE WITH A STONE IN WHARTON'S DUCT AS THE CAUSE.*

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Cancer of the tongue is relatively frequent, is on the increase, and is relatively fatal. The majority of oral carcinomata seem to attack the tongue. Fraser[1] found 43 per cent of the malignancies in the mouth occurred on the anterior two-thirds of the tongue, and another 20 per cent in the adjacent palato-glossal sulcus. Patterson[2] reported thirty-one consecutive cases of malignant disease of the tongue and seven were alive at the end of five years.

In spite of the favorable location of most tongue cancers on the anterior and middle aspects—favorable for both detection and treatment—the mortality is excessive and likewise alarming. Taylor[3] reported the admission of fifty-eight cases with cancer of the tongue, of which only six were considered operable. One of those six was alive and free from disease four years after local excision and radium implantation. There was one operation mortality and four died of recurrence after operation.

It is this frequent occurrence of cancer of the tongue, the staggering mortality statistics in spite of the frequent precancerous lesion or leukoplakia stigmata, the procrastination in arriving in the office of a competent and alert surgeon, and the ineffectual remedies instituted in therapy that make the subject of paramount importance and impelling interest. Hence the motive in presenting this paper, including the report of a case directed to my care by an observant member of the Honolulu Dental profession.

Irritation has been assigned an important role in malignancy of the tongue, probably of importance in the localization of the majority on the anterior two-thirds of the tongue. This form of irritation may be by carious teeth, ill-fitting plates or in-lays, pyorrhea, septic oral infections, and mycotic infestations (especially Vincent's organisms). In Hawaii we frequently observe other factors, which conceivably may be irritating, such as sugar cane. We, as yet, do not know what damage results from chewing stalks of cane.

*Read before the Honolulu County Medical Society, November 1, 1935.

Again, we oftentimes observe our population, particularly Filipinos, chewing the betel nut. Were damage momentarily done, the black discoloration would doubtless overshadow the lesions.

Green mangoes by the thousands are eaten raw annually. A colleague on Kauai, after much pathological study, demonstrated scores of acute nephritis cases from that cause. What damage was done in the oral cavity none can tell.

Still another local method of apparent enjoyment, and conceivably resulting in tongue irritation, may be caused by smoking, especially when the lighted end is placed in the mouth until a large volume of smoke is ready for expulsion. This apparently nefarious method is common among our Filipino ladies, privately and publicly. We wonder what damage is being done thereby. It was my good fortune to examine the oral cavities of several of such smokers and there was only mildly diffuse erythema present. Bloodgood[4] observed that "now and then a patch of leukoplakia can be produced by the irritation of a tooth, especially one with metallic filling." He has given to tobacco a very important etiological role, especially when associated with other pathology in the mouth.

Electrical discharges from some dental plates may possibly be the cause of soft tissue irritation according to Ewing.[5]

Rheinhard and Solomon[6] held that "electrical action from dental metals must be classified as a source of oral irritation and should be included among the etiological factors considered in the production of pre-cancerous and cancerous lesions of the buccal cavity."

In 1888 Palmer[7] wrote that "every tooth filled with metal is a miniature battery subject to the same fundamental law of electrical circuits." His belief, still held by a large number of investigators, cannot be denied or accepted with certainty if cause of malignancy is implied.

My report in this paper would seem to point to the cause of one cancer to have been from the formation of calculus in the right Wharton's (sub-

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maxillary) duct, with resultant irritation and spread.

Mention should be made here that leukoplakia should be sought for and the importance no longer minimized. These are idiopathic, develop very slowly, and are usually on the dorsum and borders of the tongue. These are frequently seen in inveterate smokers, in which men have predominated, and may be associated with the ten times more frequent occurrence of cancer in tongues of men than in women. These leukoplakia are regarded as precancerous. Sturgis and Lund[8] made a report on 248 selected cases of leukoplakia and keratosis of the mouth or lip entering the Huntington Memorial Hospital 1918-1926. None had malignancy upon entering, but there were twenty-five who did have it within five years with twelve deaths resulting from the same.

Curry[9] concluded that "any ulcer, wart or induration around a fissure of leukoplakia patch occurring in middle-aged individuals, lasting more than three weeks, should be considered as malignant until proved otherwise." From the leukoplakia, advancement of the disease is so insidious that examinations should be the rule at regular intervals. Curry stated that cancer may begin:

1. "As an ulcer, with a warty bare, hard indurated edge and thickening of the underlying tissues;
2. "As an indurated wart;
3. "As a cauliflower-like or papillomatous growth;
4. "As an induration in a crack or fissure; and
5. "As a diffuse infiltration of the tongue, so that the tongue becomes hard and puckered."

It can readily be seen how almost invisible areas may assume the appearance and consistency of at least four of the five enumerated methods, especially when irritative foci are not removed. Taylor[10] reported that twenty-two out of 109 cases of cancer of the buccal mucosa had leukoplakia. Further, he stated, "Trauma from carious teeth or ill-fitting dentures seemed to be directly antecedent to the development of cancer in twenty-one cases."

Warren and Gates[11] held that a predisposition or susceptibility to cancer may exist in certain people; also, that systemic conditions may be of great importance, such as lack of vitamin A. Lues, very frequent in leukoplakia or cancerous individuals, was considered important. We hear of cancer tendency, but we still surmise more than can be definitely proved.

Various aspects of cancer constituting incidence, sex, types, differential diagnosis, signs, symptoms, spread, and treatment, would constitute volumes too great for adequate study here.

In diagnosis, however, we must note that biopsy is the rule, rather than taking greater chance of future autopsy. None have definitely proved that biopsies have spread cancers.

As to treatment, we might mention that surgery by knife, electrocoagulation, radium, the cautery knife, are all used to good advantage in tongue cancers, and, with apologies to the X-ray men here assembled, X-ray to a lesser degree in therapy. Except as a palliative the latter is less effective in treating tongue cancer than elsewhere in the body.

Authorities generally agree that surgery should include the excision of all palpable neck glands drawing cancer of the tongue. Some believe they should be removed even though they cannot be palpated. Fischel[12] concluded that "surgery as applied to lymph nodes of the neck in cancer of the lip and buccal cavity was most important," stating that 90 per cent of cases of cancer of the mouth have palpable clavicle lymph nodes, of which number 70 per cent showed cancer present.

I wish here to review briefly the anatomy and histology of Wharton's (submaxillary) duct. It is usually two to two and one-fourth inches in length, running anteriorly from the submaxillary gland which is in the floor of the mouth under the posterior portion of the mandible. Wharton's duct is the main duct from the gland and it empties on the side of the frenulum of the tongue. This duct is lined with columnar cells. Approaching its termination there is a gradual transition to the stratified squamous epithelium upon which surface it opens.

The data relative to Wharton's duct was given because of the likelihood of the origination of a cancer which invaded the near-by tongue structures in this report. We may surmise that irritation of the duct took place, followed possibly by stasis and infection—a background patent for formation of calculi. Once formed, the floor of the mouth became irritated and excoriated and cancer resulted.

CASE REPORT

H. K., a Japanese male, age sixty-nine, came to my office June 4, 1935, complaining of slight in-

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termittent pain and discomfort of tissues adjacent and including the left portion of the tongue opposite the second and third molars. This was accompanied with slight discomfort on tongue movement on the affected side. Those symptoms had been present about nine months. Concurrently, the upper plate fitted less snugly and his mouth had been becoming more dry. He therefore consulted a member of the dental profession, who, observant and resourceful, became suspicious of an inflamed area on the tongue and tissues near the molar teeth and referred him to me for diagnosis and therapy.

The right submaxillary gland was diffusely swollen, soft in consistency and there was merely a suggestion of fluctuation or tenderness. No cervical glands were palpable and no definite enlargement of any structures, except the submaxillary gland and a growth on the right of the middle half of the tongue. On bimanual palpation an indurated mass was felt about the size of a thimble on the right side of the tongue and adjacent tissues. Pressure upon the submaxillary gland and on this mass caused no apparent flow of saliva into the mouth. Tenderness was elicited only of mild degree on palpation.

The area seen adjacent to the second and third right molar, including the tongue, was inflamed moderately, and in the center a small teat-like projection was presenting. This area with the corium was biopsied with the following report from The Queen's Hospital: "It is very firm, not friable. Section shows squamous epithelial cells growing deep into tissue and are of spiral type. Marked infiltration of the polymorphonuclear neutrophile leucocytes and plasma cells with predominance of the former. This appears to be a very slow growing type with no tendency at pearl formation. Diagnosis: Spiral cell epithelioma with secondary infection."

With those findings it was agreed that the growth should be removed by electrocoagulation. This was done on June 11, 1935, including an area 2½x2½ cms. in diameter or more than three times the diameter of the growth. Upon inserting the instrument in the center of the mass with the final application of the current on that date a hard mass was encountered about three millimeters beneath the surface. It was left in situation as it was firmly imbedded. Later upon removing the slough an oval calculus was found in the center which measured about ½x½ cm., and was very hard with sharp edges. At that time when pressure was made upon the submaxillary gland on the affected side saliva in jets exuded in the direction of the cavity.

Since then it has been necessary to use electrocoagulation twice. The area has healed rather evenly and there is no evidence of malignancy. The submaxillary gland returned to its normal size and consistency and the remaining proximal portion of Wharton's duct is patent and apparently functioning normally. The patient has gained ten pounds, has no more dry mouth, discomfort or other untoward symptoms, and states that he feels greatly improved generally.

As there is no glandular adenopathy, it does not appear that excision of glands would be warranted.

COMMENT

Cases of cancer of the tongue caused by calculus in Wharton's duct apparently are of rare occurrence, as no reference to the literature of same has come to my knowledge.

Likewise, the case reported was operable, receiving early treatment solely due to the vigilance and suasion of a member of the Honolulu dental profession.

In general, cancer of the tongue exacts an extremely high mortality.

In future more care in searching for precancerous lesions with careful follow up seems imperative.

Our efforts should converge in eradicating the possible irritation methods many of which are peculiar to the tropics.

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SECONDARY ANEMIAS AND THEIR TREATMENT.*

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Although it seems rather old fashioned in comparision with some of the recently introduced hematological terms, the term secondary anemia is still a desirable one because it makes cognizance of the etiological factors in these diseases.

Because of recent advances in hematology, practically all the anemias may now be classified as "secondary" to some specific etiological agent. Even pernicious or Addisonian anemia, the outstanding "primary" anemia, is now known to be secondary to an absence of intrinsic and extrinsic substances; this anemia, however, will not be discussed in this paper.

Perhaps the greatest number of cases of secondary anemia are those secondary to a deficiency of iron. In this category the outstanding type is hypochromic anemia. In its classic form, hypochromic anemia is the older chlorosis, a disease which responds readily to iron. Under its modern name, hypochromic anemia, whether it is assumed to be the result of iron deficiency alone, or iron deficiency plus a gastric disturbance, it is now recognized to result from insufficient formation of hemoglobin.

The ordinary case of hypochromic anemia is rather satisfactory to treat, (Fig. 1) particularly if there is a reduction of erythrocytes to two or three millions, with a corresponding hemoglobin value (preferably determined by the Sahli method) of from thirty to fifty per cent. Iron in most any form is the therapeutic agent of choice and, correspondingly, upon beginning its administration there will be an increase in both erythrocytes and hemoglobin, the more prompt response being on the part of the latter. The rapidity with which the erythrocyte count and hemoglobin reach the normal level, in other words, the rapidity of cure of the patient, is determined to a considerable extent by the iron containing substance chosen for administration. Of iron containing compounds, perhaps still the most satisfactory as regards ease of administration, cost and results obtained, is iron and ammonium

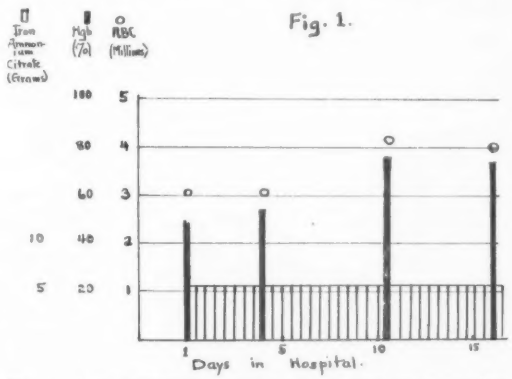

Fig. 1.—J. H., showing response to 6 grams iron and ammonium citrate daily in a case of hypochromic anemia resulting from marked dietary restriction.

citrate in gelatin capsules. The usual daily dose of 3 grams (two capsules after each meal) may be increased to as much as 12 to 15 grams daily if necessary or if desirable (Wintrobe and Beebe). Thus with large doses, cases of refractoriness to this particular substance vanish (Witts; Mills). Diarrhea, alleged to be a very disturbing accompaniment of ferric ammonium citrate administration, is actually of little importance unless doses considerably exceed the usual 3 grams daily. During the early period of its administration the effectiveness of the iron and ammonium citrate or other iron

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containing compound can be estimated by comparing the actual response with the expected 0.15 to 0.2 grams daily hemoglobin rise, or the reticulocyte rise which should reach a maximum value in from five to ten days (Minot and Heath).

Other forms of iron are giving satisfactory results in the treatment of hypochromic anemia; Blaud's pills (ferrous carbonate) contain, however, only 10 per cent of iron as compared with 17 per cent of iron in ferric ammonium citrate. Reduced iron (2 to 3 grams daily in capsules), ferrous lactate, ferric glutamate and ferrous sulphate are other substances in use at present. One caution is necessary: iron by subcutaneous injection is either valueless, as reported by Witts, or, if given in adequate dosage, is very toxic, as shown by Heath and coworkers. Dilute hydrochloric acid in doses from 10 minims to 2.5 drachms, well diluted with water, is indicated where achlorhydria exists.

Of the remaining anemias resulting from deficiency of iron, the hypochromic anemia associated with idiopathic steatorrhea, the hypochromic anemia associated with neoplasms of the gastro-intestinal tract or following gastric operation, all respond well to adequate doses of iron, within limits however, but usually without necessity of additional administration of liver extract or vitamin B subtances.

The anemia of latent scurvy, of particular importance as regards certain cases of "ecchymosis on the skin and mucous membranes with hemorrhage from the gums" (Vaughan) responds readily to vitamin C administration, in the form of orange juice, or in the recently introduced crystalline form which may be given be the oral or subcutaneous route. There is immediate rise in reticulocytes and steady increase in erythrocytes and hemoglobin following vitamin C administration alone, in this type of anemia.

The second important etiological factor, excess loss of blood, is responsible for many interesting anemias. It was by the production of this type of anemia in dogs that Whipple was able to determine that liver is a most potent hematopoietic stimulant, with kidney tissue next, and iron the most potent of the inorganic substances.

Clinically, this type of anemia is exhibited in purest form in sudden massive hemorrhage from a peptic ulcer (Figure 2). Once the acute phase is concluded, treatment is the same whether the hemorrhage was single and of large amount, or recurrent and of small amount. As in the experimental work, whole liver or whole liver and large doses of iron are valuable (Murphy and Powers; Keefer and Yang; Vaughan). As noted by Vaughan, additional treatment with meat, fruit and green vegetables whenever possible, is necessary to offset the deficiencies of the usual bland gastro-intestinal diet.

Fig. 2.

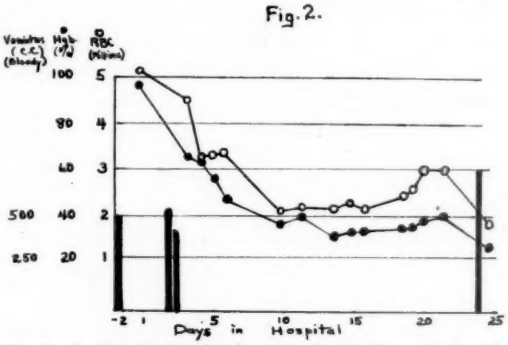

Fig. 2.—A. R., showing development of secondary anemia following massive hemorrhage from peptic ulcer.

In hookworm disease, the two factors of gastro-intestinal derangement (Rhoads and Castle) and loss of erythrocytes by their ingestion by the worms (Wells; Whipple) are best combated by removal of the worms, adequate diet, replacement of the gastric hydrochloric acid if absent, and adequate amounts of iron by mouth. Other rarer cases of excess blood loss, such as hemophilia, hereditary hemorrhagic telangiectasis and thrombocytopenic purpura, are treated in similar fashion once the anemia is established, but, in view of the promising, although temporary, local hemostatic properties of tiger snake venom (Rosenfeld and Lenke), development of secondary anemia would seem to be precluded in certain of these cases if used early enough.

The third etiological factor, namely, excess blood destruction, occurs classically in acholuric jaundice or hemolytic icterus. The only satisfactory treatment for this anemia is splenectomy, which is followed not only by practically immediate disappearance of the anemia but also in great clinical improvement of the patient (Vaughan). There is corresponding disappearance of the microcytosis and reticulocytosis. "Liver, iron, and other hematopoietic remedies are valueless" (Vaughan). Sickle cell anemia requires use of most of the measures of value in treating various other anemias before any results may be expected or obtained.

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The fourth group of anemias, those secondary to circulating toxins, are caused by such chemicals as benzene, phenol and other organic chemicals, and nephritis. If benzol anemia is taken as an example of the type secondary to chemicals, there are so many ways in which the bone marrow is affected, depending upon the dose and period of exposure, that the only directions for treatment which may be given here are general ones, namely, remove the patient from the offending agent, watch for evidences of tiring or exhaustion of the bone marrow (chiefly by study of cells obtained by sternal marrow biopsies) and give supportive but not too stimulating treatment in order that new erthyrocytes might be produced.

In the early stages of nephritis when there is little retention of the nitrogenous products normally excreted, the mild secondary anemia responds somewhat to iron, that is, the erythrocyte count may rise from 3.8 to 4.3 millions following 3 grams of iron and ammonium citrate daily. In the advanced cases of nephritis neither iron nor liver is effective (Figure 3).

Fig. 3.

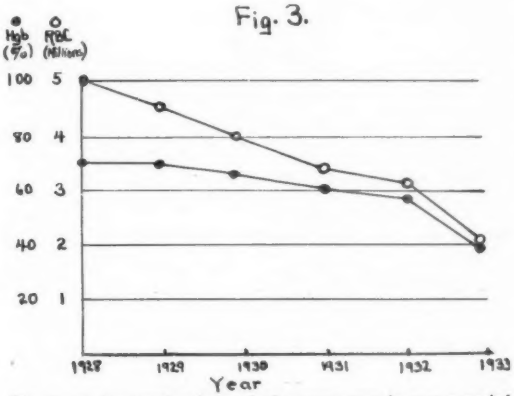

Fig. 3.—R. G., showing increasingly severe anemia over a period of five years, despite iron and liver administration in a case of chronic glomerulo-nephritis.

The above discussion has considered only those cases in which response to therapeutic measures is both prompt and satisfactory. However, conditions other than this hold in many instance. First, the response to usual measures may be delayed, so that, if the measures are continued for a sufficient period of time, satisfactory results may be obtained; second, the anemia may persist, and not show any response to the usual measures; or, finally, the condition may become progressively worse despite even the most painstaking therapeutic measures.

Under such circumstances it is not enough to rely upon the diagnosis from the circulating blood alone, assuming that all possible etiological factors had been investigated during the period of initial consultation, but rather it is important to determine the condition of the entire erythron, that is, the condition of both the circulating blood and the bone marrow. Thus, in the absence of direct tests which would be valuable in showing the presence of abnormal substances in the blood forming tissues or in the circulating blood, the condition produced by these abnormal invading agents must be taken as an indication of the kind of treatment necessary. By this token, even though the majority of cells of the circulating blood were microcytes (i. e., less than 7.5 microns in diameter), if large numbers of erythroblasts were present in the bone marrow obtained by sternal puncture, whole liver or liver extract would be indicated. The missing maturation substance thus would be supplied. When the marrow contains an excess number of cells of the myeloid series, even though the leucocytes of the circulating blood are not especially abnormal, treatment should be directed towards the leukemia more particularly, and towards the secondary anemia only secondarily. When the bone marrow contains only a few cells of either the myeloid or erythroblastic series, the response to measures designed to increase either or both types will be disappointing. There are no therapeutic agents at the present time effective in treating anemia secondary to aplasia of the bone marrow.

In summary, the etiological factor is known, within certain limits, in practically all types of secondary anemias. Treatment of the iron and vitamin deficient types is replacement in nature. Treatment of excess loss of blood consists in supplying adequate amounts of iron and foodstuff necessary for erythropoiesis. Treatment of secondary anemia resulting from toxins consists in removal of the offending agent. Finally, prevention of aplastic anemia is the only way of combating this disturbance, because of the ineffectiveness of all therapeutic agents used in this disease.

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REPORT OF TWO CASES OF TUBERCULOUS PERITONITIS DUE TO BOVINE TYPE FROM SAME FARM.*

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It has been known for a long time that man becomes infected with the bovine type of tubercle bacillus, the two types having been differentiated by Theobald Smith in 1879. However, Koch, who discovered the tubercle bacillus in 1882, disputed the fact as late as 1908, that the bovine type was pathogenic for man, and this contention led to a great deal of research which has now acceptably disproved Koch's statement. The incidence of bovine tuberculosis as a definite cause is relatively unimportant. Wang reported a series of 1,273 adult cases with only thirty-eight of the bovine type, and in the same series there were twenty-four abdominal cases with seven of the bovine type. Griffith found bovine bacilli in 1.1 per cent in all cases of pulmonary tuberculosis. Corbett called the attention of the profession to the high incidence of bovine type in infection of cervical nodes and alimentary infection in children and its seeming unimportance in the lungs. Brown and Hayes state that 6.5 per cent of all deaths from tuberculosis may be attributed to the bovine bacillus.

This shows the comparative unimportance of bovine type as a cause of tuberculosis in human beings. The bovine type is recognized as being spread by ingestion of milk from cows having active tuberculosis, which makes us feel that the emphasis on the testing of cattle is highly important as a control measure.

About 1924 the numbers of scrofulous glands in children became so noticeable in our community that steps were taken to find the cause. The several dairymen supplying the town with milk were approached with an idea of getting a cooperative and general testing of the cattle, and to this they freely assented. From the herds supplying the community with milk at that time there were about twenty-five cows found to be reactors. This was high being about 40 per cent of the whole. One of these herds alone had seventeen cows out of a total of twenty-three proved infected with tuberculosis, and, strange as it may be, from the same farm came our two cases of peritonitis. These facts are added as they helped materially in making the diagnoses.

It is added with no little degree of satisfaction that since these infected cattle were destroyed in

*Read before the Mid-Tidewater Medical Society at its meeting in Saluda, Va., April 27, 1936.

1925 and our herds have been tested regularly, there has not been a single case of scrofulous gland to leave its ugly scar to mar the appearance of our children. Unfortunately they seem to occur with much greater frequency in girls.

CASE REPORTS

CASE 1. Mr. G., age fifty-eight, married, dairy farmer, proprietor of the farm concerned.

F. H. Nothing of importance.

P. H. Gave history of probable ruptured appendicitis in past.

Pres. H. Began with cramp-like pains in abdomen, which required morphine to relieve. Had recurrent attacks with increasing frequency. His general health became impaired and at my suggestion he went to see Dr. O. O. Ashworth, Richmond, Va., who reported as follows under date of November, 1929:

"Briefly my impression in his case is that his ascites is from a portal cirrhosis. However, (1) he has a very few dilated veins over the lower chest; (2) chronic hypertension; (3) slight cardiac hypertrophy; (4) chronic myocarditis, B. P. 180/100. The left border of the heart seemed to extend somewhat abnormally to the left. His axillary arteries are definitely palpable and there are occasional extra systoles; (5) small pharyngeal polyp; (6) irregular dilated pupil rt. (from injury); (7) hyperpituitary; (8) atrophy of left testicle; (9) laboratory findings: Wassermann negative. Hmg. 90 per cent. Red count 5,000,000; White count 8,000; Lym. 26; Neutro. 71; Eosin. 2. Urine: Hyaline and granular casts. Heavy trace albumen.

Personally, I would feel better about this case if we could tap him and rule out any inflammatory condition of his abdomen."

November 15, 1929. Man was tapped and numbers of acid fast bacilli were found. Guinea pigs were injected. Opinion now that man has a low grade tuberculosis peritonitis, of bovine type.

February 28, 1930. Fluid still collecting in peritoneum. Drawn off and air injected in its place. Bacilli abundantly free in the fluid.

October 28, 1930. Laparotomy at Danville (by Dr. S. E. Hughes) who reported by letter to Dr. Ashworth, October 27, 1930:

"The operation revealed a rather unusual condition. No tubercles were found on the peritoneum or about the head of the cecum but numerous small nodules were found on the omentum—more numerous on the greater omentum. Your diagnosis of tubercular peritonitis is probably correct but I am inclined to the opinion that there must be some complication of the portal circulation."

December 2, 1930. Patient died. Autopsy showed in addition to the above information, a typical hobnail liver and meningitis. The causative organism of the meningitis has not been determined. (Letter Dr. Ashworth to writer.)

CASE 2. Mr. H., age twenty-nine years, white male, married, paper mill worker. Moved to the above farm after Mr. G. had vacated it and lived there about two years.

F. H. Nothing of importance.

P. H. Influenza. Broken leg and fractured skull 1925 as result railroad accident. Shortening of right leg.

Pres. H. About eighteen months ago he began to have attacks of pain in belly, which lasted several days. Usually began with constipation and developed pain afterwards. On one occasion in July, 1933, he was seen by another doctor who told him that he had appendicitis, on the strength of which he was taken by me next day to confer with a surgeon who did not feel there was sufficient evidence at that time to operate. Early the next morning he had an unexplained convulsive seizure. Subsequently, at varying intervals, he had similar attacks of pain, discomfort, loss of appetite, gurgling, constipation, etc. About August 15, 1935, he began to have pain, was constipated and since then he has had a pain in lower part of abdomen. Fills up when he eats, though he is hungry, and eats very little. He has not been free from pain since it began six weeks ago. Lately he has been swollen, through abdomen.

Physical Examination: Heart normal. Lungs: few scattered rales. B. P. 130/82. Rate 86. Abdomen: Distended, tense. No areas of tenderness or masses. Feels like fluid.

Laboratory Findings: Urine about normal. Few pus cells; Red cells 4,630,000; White cells 7,400; Hmg. 92 per cent; Pmn. 27; Sm. L. 18; Eosin. 55.

Sedimentation test shows a diagonal line with sedimentation index of two at end of an hour. X-ray conclusion: There is evidence of an inflammatory process—chiefly in the hilum. There is also evidence of a good deal of bronchial thickening, but there are no soft unhealed tubercles made out. Some

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thickening of the right interlobar pleura with effusion.

September 29, 1935. Laparotomy by Dr. F. S. Johns, Johnston-Willis Hospital, Richmond, Va., disclosing a large amount of free cloudy fluid which was siphoned off. The upper abdomen, especially around the stomach, showed some atypical nodules, which were considered most probably an early tuberculous peritonitis.

April 8, 1936. The acid fast bacillus cultured and injected into a ginuea pig showed a tubercle nodule, proving the diagnosis of tuberculosis of bovine type. (Letters of Dr. D. B. Cole, quoted above.)

DISCUSSION

We do not expect to add anything to the knowledge of tuberculosis. It seems that lightning strikes in the same place twice. The diagnosis in these two cases, while proved by laboratory findings, was clearly pointed out by the past history and the incident tuberculosis in the herds on the plantation. There had been cases of tuberculosis on the place long before this, which may have too been connected with the barns, etc.

We do not feel that the presence of two cases has proved the presence of tuberculosis in the barn but we would certainly not put a clean herd of cattle in the same barn. That is a matter of opinion. There was no history of prior tuberculosis in either of these cases, no contact history, and no connection between the two, they occupying the farm after each other, and on this we are basing our deduction that the source of infection was from the farm.

The general testing of cattle will probably entirely eliminate bovine type of tuberculosis from children, as it has ended the scrofulous glands in our community. The disappearance of the type of infection undoubtedly goes with the more stringent laws governing milk production. Milk ingestion in children would seem to explain the higher incidence of alimentary and gland infection in children than their personal habits of putting things in their mouths.

The second case six months after the operation appears well and states that he feels fine. He is back at his former occupation. The only treatment he had after returning home was sunshine, an abundant diet, and rest. It is to be hoped that he will remain well.

We wish to express to Drs. O. O. Ashworth and Dean B. Cole our thanks for their able assistance and advice in these cases.

SUMMARY

1. Two proved cases of tubercular peritonitis due to the bovine type of tubercle bacilli are presented and are traced to residence on the same farm.

2. The significant disappearance of scrofulous glands in the community after destroying tubercular cattle is noted.

3. The similarity of the abdominal symptoms to those of appendicitis and the dependence on a thorough study to make a differential diagnosis are emphasized.

4. The advantage the family physician has in knowing the details of environment and history in diagnosis is in these cases fully illustrated.

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AN UNUSUAL CASE OF STRICTURE OF THE ESOPHAGUS.

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The most frequent cause of benign stricture of the esophagus is the swallowing of corrosive fluids. Among these, lye solution is overwhelmingly preponderant.

Von Heindl[1] collected statistics of 137 cases of chemical burns of the esophagus. In this series, 73 per cent were due to lye. Von Hacker[1] in a larger series of 477 cases occurring within a period of nine years in all the hospitals of Vienna found that in 70 per cent lye was the etiological agent. Vinson[2] of the Mayo Clinic tabulated the causes of

*From the Department of Oto-Laryngology of the Medical College of Virginia.

186 benign cicatricial strictures of the esophagus. This included benign strictures from all causes, chemical, inflammatory and congenital. In this group 52 per cent were due to lye. Lye burns constituted an even higher percentage of chemical burns, viz., 84 per cent.

There are many other chemicals which will cause burns of the esophagus. Among those mentioned in the literature are nitric, hydrochloric, sulphuric, carbolic, acetic, chromic and oxalic acids, lysol, bichloride of mercury, copper sulphate and silver nitrate.

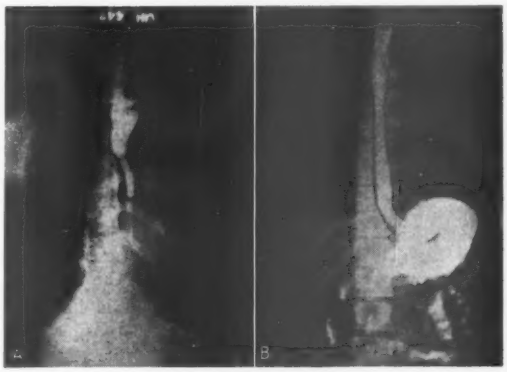
CASE REPORT

Mrs. V. B. T. (referred by Dr. Clifton Miller), age thirty-one years, white, married, complained of inability to swallow, even water being regurgitated.

Present Illness. Three days before consulting me she noted increasing difficulty in swallowing. For the last twenty-four hours the patient stated that she was unable to swallow anything. Liquids were immediately regurgitated.

Past History. The patient at six months of age was a healthy infant who had no previous difficulty in nursing. While attended by her nurse the infant put a brilliantly multi-colored East Indian print handkerchief in her mouth. The lips and mouth were stained by the dye and there was a rapidly progressive edema of the lips, mouth and tongue. Dysphagia immediately ensued. The next day the patient with great difficulty was able to swallow. This continued until the child was two years of age. On account of the extreme difficulty of swallowing and the resulting malnutrition the child's life was despaired of. At this time the child was brought to Dr. Miller. Since esophagoscopy was not available at this time a whalebone bougie was used. By continued use of the bougie the child was enabled to drink liquids and eat soft food that had been strained through a fine sieve. These treatments continued until the patient was eight years old. At this time the patient did not report for further treatment. Although she was unable to swallow anything but liquids and finely divided solids, the patient did not consult a physician again. Until the present acute difficulty at the age of thirty-one, she led a normal life, was married, and maintained herself in fairly good health except for considerable emaciation.

Examination and Treatment. X-ray studies showed a stricture in the lower third of the esophagus with complete stoppage of the barium mixture. Esophagoscopy was done under local anesthesia. A dense white fibrotic area was found at 30 cm. from the upper teeth. The entire esophagus was occluded except for a centrally located opening which admitted with difficulty a 12 F. bougie. This was dilated under visual control until a 16 F. bougie could be passed.



A. Before dilatation. B. After dilatation.

After esophagoscopy the patient was again able to swallow liquids. Over a period of four months successively larger bougies have been passed over a swallowed thread. At present a No. 34 bougie can be passed.

The patient has gained weight and is able to eat a regular diet. It is proposed to carry treatments further until a 45 F. bougie can be passed.

COMMENT

Although the history of this case dates back over thirty years, the etiology seems to be certain. Since the case was so unusual the father at the time of the accident tested the caustic quality of the dye. He placed the handkerchief in his mouth for a very short time. There was an immediate burning sensation and edema of the mouth and lips. The handkerchief was submitted to Dr. William H. Taylor, well-known chemist and toxicologist of that day, who reported that it contained a very caustic dye.

Besides the unusual nature of the etiologic agent the case presents the remarkable feature of a person whose diet was practically liquid for thirty-one years and whose health has been well maintained.

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A CASE REPORT.

JOHN R. HAMILTON, M. D., F. A. C. P.,
Nassawadox, Va.

The following case is reported because of the diagnostic problem it presented, the large doses of sodium cacodylate administered in its treatment, and the clinical improvement obtained.

The patient was referred on April 4, 1935, by Drs. W. L. Cosby, H. L. Denoon, and W. C. Henderson. A brief of the patient's record at that time is as follows: White male, fifty-three years old, occupation fishing and farming. His chief complaint was swelling on the left side of the abdomen after eating. For the past four months had just not been feeling well. Ten weeks before there had appeared a painful lump under the left arm and, later, lumps developed under the other arm and in the groins. During the same period he developed a severe cough, believed that he had run some temperature, and stated that recently he had been nervous. His past history revealed that his only illness had been pleurisy in his left side.

On examination he gave the appearance of having suffered a recent loss of weight; his skin and mucous membranes were pale; temperature 99.6; pulse 120; respiration 16; teeth in poor condition; lungs had moist rales in both bases; circulatory system showed no pathology; blood pressure 130 over 60. There was a large mass believed to be the spleen practically covering the left upper quadrant of the abdomen. The axillary and inguinal lymph glands were markedly enlarged, distinct, and not tender. The examination other than above showed no pathological findings.

The laboratory work, done by Mr. A. A. Shanks, was as follows: Sahli hb. 55 per cent; w.b.c. 5,500; r.b.c. 4,016,000; polys 28 per cent; lymphs 70 per cent; myelocytes 2 per cent; blood smear showed marked anisocytosis; color index 0.7; coagulation time eight and one-half minutes; Kahn test negative; agglutinations for typhoid, tularemia, Malta and Flexner negative; blood culture negative. A gland removed by Dr. W. C. Henderson from the inguinal region on examination by Dr. Wm. A. Shepherd was classified as a simple lymphoma with further clinical observation necessary for diagnosis.

It was my feeling that the case was either Hodgkin's disease or lymphosarcoma with the preponderance of evidence in favor of Hodgkin's disease.

The treatment from April 4 to August 22, 1935, was started with Blaud's pills, ninety grains a day. The response in the hemoglobin rise was satisfactory and the Blaud's pills were gradually decreased. On July 30th, this medication was discontinued when the hemoglobin was 90 per cent, and no further iron medication has been required. Fowler's solution was first administered on April 4th, beginning with nine drops a day and gradually increasing to thirty drops a day, with one week's rest from this medication allowed out of each six weeks. This rest period was found necessary because of edema under the eyes which promptly disappeared on the withdrawal of the Fowler's solution, and did not recur after the rest period had been included in the schedule of treatment.

During the period from April 4 to August 22, 1935, the cough gradually became worse, first requiring cough syrups; then codeine in half grain doses, which had to be increased to one grain doses; and, finally, morphine grains one-eighth was given; and as many as four of these in twenty-four hours were required to keep the patient moderately comfortable.

During the same period the glandular enlargement became general; the glands increased in size, some reaching the size of hen eggs; they remained firm, discrete, and not tender. The spleen gradually enlarged until it filled the left side of the abdomen and extended to the crest of the ilium. At this time, August 22, 1935, the patient's skin was a bronze color, the cough racking in character and almost continuous, edema of the legs had developed, emaciation and weakness were severe, laxatives were re-

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quired for each bowel movement, and, except that his appetite and food intake were good, no encouragement was to be had.

Beginning August 22, 1935, sodium cacodylate was administered intramuscularly at bi-weekly intervals, the dose being increased from three-fourths of a grain to one and a half grains, then to three and six grains. While no physical change had taken place, the patient stated on September 7, 1935, that he felt better than he had for months. On September 18th, the dose was increased to seven grains. On September 21st, the spleen had decreased to approximately one-third of its size at the beginning of the administration of the sodium cacodylate; but the cough still required two morphine pills of an eighth of a grain for its control, and very little if any decrease in the size of the glands was noted.

By October 19, 1935, the patient, while still unable to work, was greatly improved in the way he felt. The spleen had decreased until it was two inches below the costal margin, and the glands were reduced to approximately one-half their maximum size. Only one-eighth of a grain of morphine was now required in twenty-four hours for the cough, and bowel movements were obtained with less laxative. No toxic symptoms having developed, the dose of sodium cacodylate was increased to fifteen and a half grains.

By December 7, 1935, the patient had no complaint. The spleen could not be palpated, glands had decreased until only a few could be felt in the neck and groin, and these were about the size of an almond. No medication was required for cough or for constipation. The dose of sodium cacodylate was changed to fifteen and a half grains once weekly. When seen on December 31, 1935, the patient had a severe chest cold which was symptomless by January 18, 1936. Cough syrup and cascara were given for the cold, but general progress did not seem to be retarded. On January 22, 1936, a check-up examination showed the skin average color, the glands were not palpable except one small anterior cervical gland on the left, the spleen could not be palpated, and the patient was doing a full day's work without becoming unusually tired.

The weather and condition of the roads made dosage irregular over the winter period, though he came as frequently as he could manage transportation. In February, 1936, he received six doses of fifteen and a half grains of sodium cacodylate. Since March, 1936, he has complained of some fulness in the left upper portion of the abdomen after eating large meals. During this month two diseased teeth were extracted without any complications arising.

On April 4, 1936, the patient was working as laborer on the road, was symptom free, weighed 160 pounds, a gain of forty pounds, and, on examination, showed no glandular enlargement and the spleen could not be palpated. On April 16, 1936, the dose of sodium cacodylate was reduced to seven grains; on April 25, 1936, to three grains; and has been continued weekly at three grains. In this month, May, 1936, another cold developed, but gave no more than average inconvenience.

During the period from August 22, 1935, to May 9, 1936, the patient received a total of five hundred eighty-six and one-fourth grains of sodium cacodylate without signs of toxicity. He also changed from a complete invalid to a person able to earn his own living at manual labor for the present.

I should like to repeat that this case has been reported merely because of the three interesting features stated at the beginning, and not as any cure.

A DEDICATION TO STUDENTS IN MEDICINE.

THEODORE C. MERRILL, M. D.,
Paris, France.

The ideas contained in this little address, or *causerie*, are offered in a spirit of affection and regard for those who belong to the immense group interested in the technical and practical relations of medical science. As so defined, this student group includes mature and experienced physicians, surgeons and specialists, laboratory workers, hospital chiefs, practitioners of all degrees of competence and reputation, hospital internes, undergraduates in medicine and members of the nursing corps which, from its ideals and its real and intimate value, may well be considered a *corps d'élite*.

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Now, what element or quality is primarily and distinctively characteristic of students? I think we may readily agree that it is *enthusiasm*. Enthusiasm is the factor inherent in utility. Mere curiosity may be languid, passive or temporary, but enthusiasm is vital, active and persistent. It is basic in medicine because, in the promotion of its purposes, it implies the possession of other qualities, especially those of tolerance, sincerity and impartiality. It is exemplified in the life of Pasteur and admirably expressed by Pasteur's familiar principle, "I do not know; I will investigate."

Every advance in human progress has been accomplished through the efforts of enthusiasts, from Abelard to Zondek. In medicine, enthusiasm has motivated a multitude innumerable of students. Among the names familiar to us all are not only those of Hippocrates, Galen and less remote pioneers in anatomy, physiology and therapeutics, but such names as Ambroise Paré, Larrey, Laennec, Harvey, Ronald Ross, Ehrlich, Carrel, Billroth, Banting and Best, Widal, Virchow, Koch, Jenner, Whipple, Florence Nightingale, Metschnikoff, Matas, Babinski, Schaudinn, Osler, Semmelweiss, Lister, Trudeau, von Pirquet, Pinel, Behring, Councilman, Einthoven, William W. Keen, Claude Bernard, Yersin, Welch, Pavlov, Clara Barton, Klebs and Loeffler, Cajal, the Mayos, Castellani and, may we not add, Edith Cavell.

These names constitute eloquent testimony to an enthusiasm always identical with a capacity for being, eternally and irrepressibly, students. As presented, they require rapid mental leaps, backward and forward, from epoch to epoch, clime to clime and place to place. The list thus offered is sufficient, yet admittedly incomplete, although still other names fortunately appear elsewhere in this commentary. Not one but will arouse recognition and homage in the mind of anyone who is familiar with the history, not only of medicine, but of humanity. Not one but must evoke a sentiment of humility in anyone who would claim a place in the endless caravan whose units, whatever their grade of brilliance, remain but students, after all.

Enthusiastic pursuit of the vital interests of science, and for our present purposes, of medical science in particular, brings rewards which are not necessarily of placid character. It may result in brusque and decisive extinction, as in the fatalities terminating the careers of men like Curie who, absorbed in reflection, was struck by a vehicle and killed, in Paris; or like Ricketts, succumbing to the infection of Rocky Mountain fever; or like Lazear and Noguchi, both of whom yielded up their lives to the yellow fever which they were studying. An application of a misplaced sense of humour, as well as of sheer dread, may possibly prevent some minds from enlisting in warfare against minute but potent agencies of infection, but no wholly riskless game is likely to appeal to personalities of courage and spirit. Those who shirk adventure often miss what is best in life.

As exemplified in medicine, enthusiasm may have many aspects. One form is that typified by the lives of medical missionaries or of physicians like Grenfell of Labrador; or Watrous, a contemporary worker obliged to surmount problems in medicine, surgery, obstetrics and several of the medical specialties, in a vast stretch of territory extending throughout large sections of the Philippines; or, again, Dafoe, who has overcome a host of obstacles in successfully preserving the lives of the famous quintuplets. This aspect is familiar to a huge array of physicians quite unknown to fame, yet who have met and are meeting far-flung responsibility with their own keen wits, dauntless spirit and tireless fidelity to their tasks in proving what can be accomplished by educated intelligence and resourcefulness, otherwise largely unaided.

Another variety of enthusiasm is that of the devoted laboratory worker who, if he wish to achieve supreme excellence, must eliminate from his existence almost everything save his immediate labours. What glowing examples of this form arise before one's vision at the mere mention of the Pasteur Institute! Pasteur and Roux repose within the terrain in which their fruitful labours evolved and were concluded. It has been my fortune many times to accompany visitors to this shrine of science and I cherish memories ineffaceable of Professor Roux, sitting quietly and unobtrusively, yet a type of unassuming greatness, in the Economat, or business office, of the Pasteur Institute at Paris, and always freely granting opportunities of visiting the Institute, quite regardless of day or hour. The ideals animating these spirits shine brilliantly clear, for all the world to see, above the impressive descent to the crypt where sleeps Pasteur amid the aureate mosaics which testify to the immortality of his achievement: "Happy is he who bears within him-

self a God, an ideal of beauty, and follows its guidance; an ideal in art, an ideal in science, an ideal native land, an ideal penetrated by the virtues of the Gospel." I add the French original, both for its own sake and in order that there may be no omission of the beauty and exactness of the thought: *"Heureux celui qui porte en soi un Dieu, un idéal de beauté, et qui lui obéit; idéal de l'art, idéal de la science, idéal de la patrie, idéal des vertus de l'Evangile."*

Finally, enthusiasm is the most powerful agent for the preservation of mental elasticity, without which scientific interest and activity cannot continue any vigorous and practical existence.

It was mentioned a few moments ago that enthusiasm in medicine should be inseparable from tolerance, sincerity and impartiality. Tolerance! After all, what more delightful and agreeable quality exists? Experience in medicine, as in life in general, comes to teach that an identical end may often be reached by any one of a plurality of roads. The field of opinion is wide. This is especially true of therapeutic applications. In a certain way, it must appear strange, indeed, that differences of opinion on scientific subjects have not seldom been, and sometimes still are, invested with acrimony. A striking example consists in the criticism and ridicule that were heaped upon Pasteur's denial of spontaneous generation. The violence of those polemics may appear puerile and unnecessary to us of the present era, since the presentation of such an important contention as Pasteur's merited at least cool consideration, yet it cannot be said that even modern controversies are invariably fraught with gentle deference and mildness.

As medical men embark on their careers, they manifest not infrequently a certain intolerance of mind. As we emerge from the modernity of our medical training, we may, perhaps naturally, consider ourselves well equipped and in possession of resources which are final. Broad acquaintance and accumulating experience, however, dispel these early notions. Relatively few amply tested resources and principles survive, while many fancies and innovations prove to be meteoric, temporary and illusive. One must retain an open mind, neither sweepingly rejecting nor blindly adopting the novelties which must eternally continue to emerge upon the medical horizon.

As enthusiasm is thus illuminated and enhanced by tolerance, its forces must be guided by a spirit of sincerity, applied as a check and a curb, in order that the greater and more forceful agent may not be weakened by self-deception. Is a good, perhaps brilliant, result obtained? If so, the successful medical beneficiary will, if sincere, remain imperturbable and little moved by elation, his equanimity experiencing no imbalance. He will recall those brief words so many times repeated in the writings of Ambroise Paré: "I treated him—God healed him (*je l'ai pansé, Dieu l'a guéri*)." If he please, he may replace the idea of divinity with the more general one of natural phenomena, remembering the ancient phrasing, *"vis medicatrix naturae."* The brilliant Einthoven, when complimented upon his invention of the electrocardiograph, disclaimed the praise, modestly insisting that he had "really done but a very little thing." Sincerity must compel our admiration for this "very little thing."

The sincere student in medicine is daily confronted with his frailty and powerlessness. While he reaches not seldom the objectives which he has defined for himself, he nevertheless very often fails to attain them. He is continually obliged to confess ignorance. If he could remain in permanent contact with his cases, he would be obliged invariably to concede defeat in the end and final inability to avert the occurrence of death, final failure to forestall the inexorable operation of natural law. This point is illustrated by the interrogation of a medical expert witness at a trial held in Chicago. The expert was of unquestionable integrity and attainment.

"You are well known here, doctor, are you not?" began the cross-examiner. "I may say so," modestly replied the witness. "You have a university and hospital position?" "Yes." "You have been practicing medicine in this city for some thirty years?" "For about that length of time." "In the course of your practice you have treated some of our well-known citizens?" The doctor bowed assent. "Well, doctor, you treated Mr. Blank, the steel man, did you not?" "I did." "Where is he now?" "He is dead." "You treated Mr. Ecks, the banker, did you not?" "Yes." "Well, where is he now?" "Er—he is dead." "You treated our packer, Mr. Wy, I think?" "Certainly I did." "Where is he now?" "He is dead, but—" "Never mind the buts, doctor. You treated Mr. Doubleyou, our oil man, didn't you?" "I did." "Where is he now? That's

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all, doctor." The physician stepped from the stand and the attorney waved a deprecating hand to the jury. However, his attempt to cast a shade of discredit upon medical powers and authority was patently in the nature of an implication and a sophistry. It could in no way create a doubt concerning the usefulness of medicine to mankind, it could not detract from the value and dignity of the medical profession, nor could it invalidate the testimony constituting authentic evidence in a duly constituted legal procedure, in which invalidation of that testimony on the basis implied by the cross-examiner would necessarily invalidate the essential principles of legal procedure and expert evidence.

The third factor, flawless impartiality, permits enthusiasm to develop its full powers. Opinions and conclusions must be controlled and tested by facts, and not by sentiment or personal bias. A broad, clear outlook must be constantly maintained, in order that results may not be vitiated by prejudice and prematurity. The principle expressed by Mark Twain is largely applicable to medicine. You will recall that he remarked that no opinion has any *ex cathedra* value whatsoever, since it may be confronted with one of equal validity. With parallel mental development and ability John Smith still decidedly differs from Jack Jones; Wagner does not agree with Mozart; Darwin and Spencer cannot accept the beliefs cherished by Cardinal Newman and the dweller in the Vatican. "Who shall decide when doctors disagree?"

The function and necessity of impartiality as applied to medicine need no further discussion here. They are self-evident. In conclusion, I would that I might capably express the pleasure and inspiration which have been charmingly conferred upon me through association with enthusiastic and active student minds, regardless of individual chronology, for chronological is not necessarily coincident with functional, age. To those who are just entering upon the manifold relations of medical theory and practice I would extend my sincere felicitations, together with my heartiest wishes for success which, in order to be ideal and genuine, must be coloured with goodness and gayety, with gentleness and with broad humanity. From such a godspeed and valedictory to students in medicine I might, perhaps, be unable to omit a certain expression of regret induced by memory of the finally inevitable extinction of vital energy which imposes arrest of all individual endeavour; yet even such fulgurant distress can be but momentary when submerged in contemplation of any measure of accomplishment which represents one's faithfullest and one's best.

10 bis rue Herran.

PROPOSED IMMUNIZATION PROGRAM.*

A. B. MCCREARY, A. B., M. D.,
Health Officer, Northampton County,
Eastville, Va.

The necessity of cooperation between the health department and organized medicine is essential to the promotion of any sound health policy.

No one places any more value upon the sympathetic and intelligent support of the practicing physicians than your local department.

Your department will have the following objectives, viz.:

1. General sanitation (proper and adequate sewage disposal).—A wholesome environment plus safe water, milk and foods.

2. The promotion of hygiene through health education with a health conscious public as the ultimate goal.

3. The reduction of infant mortality through education, demonstration and competent nursing instruction by the health nurse, especially among the under-privileged class. This service is to be rendered only upon invitation of the physician in charge of the case, and then the nurse will consult with the physician before calling upon the patient. It is to be understood that this is not a service of general

*Read before the Northampton County Medical Society, at their regular meeting at the Rafters, Eastville, Virginia, April 3, 1935.

Since presenting this paper Dr. McCreary has moved to Jacksonville where he is connected with the Florida State Board of Health.

duty nursing, but one primarily and solely of instruction to the pre-natal and post-natal patient in the proper care of herself and the baby. It is to be thoroughly understood that in so doing the nurse will take her orders from the physician in charge of the case.

4. Reduction of the number of midwives practicing in the county—with their complete elimination as the final goal,—the motive being to educate the public to realize and appreciate the greater safety to motherhood through competent medical service.

5. Inspection and examination of school children; and special emphasis upon the pre-school child. Here the physician can render a great service by urging that the children of his patients receive all the necessary immunizations before reaching school age.

The department will attempt to find the defects in the school child and refer them to the family physician for correction.

6. The reduction of the communicable disease rates through better sanitation, isolation, immunization and education.

There are three diseases at least which it is within our power to practically eliminate, smallpox, typhoid, and diphtheria. Medical science has given us the means through immunization. Smallpox has practically been eliminated from Northampton County, no cases having been reported since the epidemic year of 1928, when there were 102 cases for a rate of 5.6 per thousand.

You know, of course, that typhoid and diphtheria have been very prevalent within the past few years. The typhoid rate has been exceptionally high, 159 per hundred thousand in 1932, 132 per hundred thousand in 1933, and climaxed by a rate of 185 per hundred thousand in 1934. The department would like to stress the advisability of early blood cultures in every case of continued fever, and the department is at your service at any time for consultation or aid in the collection of the specimens. Naturally, correct diagnosis is one of the essentials of proper treatment as well as efficient preventive measures.

The Detroit and Wayne County plan of immunization is familiar to most physicians. Such a plan is not practicable in this county due to the financial demands it would make upon county government, but a modification of that plan may be practical here, and I wish to present one for your consideration. Do you know any reason why the family physician should not be the health adviser for the families that he serves? Is there any reason that he should not see that they are immunized for typhoid, diphtheria and smallpox?

Undoubtedly the easiest program for a health unit is to embark immediately upon a wholesale immunization campaign. There is some doubt regarding the lasting benefits of mass immunization through free clinics to the community. If the public can be made health conscious and taught to pay for these benefits just as they would for some other desirable thing in life, the results would probably be of a far more permanent character. People appreciate more the things for which they pay. It then has monetary value to them.

In your practice you have patients who pay and some who do not. You do practice for some whom you know cannot and will never pay.

Our plan is for you to do the immunizations on the same basis. The department will furnish you with the necessary immunizing agents at no cost to you. You will keep a record of all immunizations on cards supplied to you, the cards to be the property of the health department and filed there as a record of our expenditure for biologic products as well as a record of immunity.

The department does not attempt to dictate the fee for this service, but feels that anything more than a reasonable fee would defeat the purpose of the plan.

Through health education we will bend every effort to get the public to avail themselves of immunity by a visit to their doctor. You understand, of course, that you will have to take the scalawag as well as the prince, as any attempt to draw a line between those receiving it from the health officer and those receiving it from the practicing physician would be fatal to the plan. It should not become necessary for the health officer to step in with mass immunizations in the presence of threatened epidemics. You can fence these off by sincere cooperation with the plan.

You must all be thoroughly in accord with this plan if it is to succeed. Naturally, where a definite responsibility for a particular phase of prevention is taken over by the medical group, there must be a complete understanding, and a reasonable degree of harmony within the group itself, as well as complete

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cooperation and coordination with the legally constituted health agencies.

The rates must decline. The department owes an obligation to the 18,957 people of Northampton County to see that the rates are markedly reduced. The department must give an account of its stewardship both to the local governmental bodies and the State Department of Health.

Health authorities have neither the intention, means nor desire to encroach upon the field of curative medicine, and, furthermore, are glad to give to the medical profession all the preventive phase for which they will accept the responsibility; yet this in no wise relieves the health department of its responsibility for the ultimate reduction of disease rates.

The important functions of a health department may be considered as being within the scope of the meaning of four words. There are few activities, if any, that cannot be described as educational, advisory, investigatory or legal, and so long as this is borne in mind there is little likelihood of encroachment upon the field of curative medicine.

In order for the department to function best in such a capacity, it must have a knowledge of the presence of disease and the conditions under which it exists. An epidemiological study cannot be made, nor control measures instituted unless the existence thereof is reported to the department. Let me urge that you report promptly to the department the presence of any of the reportable diseases. I cannot too strongly urge this, if such an immunization program is to succeed. The plan may fail, or the plan may succeed. It depends on what we physicians will do about it.

We can assure you that no one will work harder for its success than your health unit. We are fully convinced that such a plan is the best method in which to serve the public, and that the benefits of health education derived will far outweigh the passing benefits of spasmodic mass immunization. The profession should take the immunizations away from public health officials and do such a good job of it that there would never be any thought of its return to public health agencies.

In closing, I want to urge the constant use of the laboratory especially in the diagnosis of typhoid and diphtheria. Take swabs on every suspected throat and blood on every typhoid suspect.

Your frank discussion is not only invited, but urged.

NOTE: At the suggestion of Dr. McCreary, and upon motion by Dr. Henderson, an advisory committee, composed of the three medical members of the County Health Board and the President of the Medical Society, was created to work with Dr. McCreary in the further interest of the plan with the hope of assuring its success.

The paper was discussed by Drs. Holland, Hamilton, Ames, Fisher, and others.

AURICULAR FIBRILLATION—CLINICAL SIGNIFICANCE.*

HARRY GOLSTON, M. D.,
Roanoke, Va.

One of the most common, easily recognizable and responsive types of cardiac conditions to therapeutic activity is auricular fibrillation.

It was the disease that made Withering famous with the use of digitalis, and its clinical existence was suspected by Cushny and Edmonds (1906) in dog experimentation with cardiac stimulation with an electric current. It was clinically proved by Rothberger and Winterberg (1909) and by Lewis two months later independently. McKenzie (1910) collaborated the clinical manifestations with the electrocardiographic findings and followed with careful notes his patients who had mitral stenosis and later fibrillated in the span of years.

Auricular fibrillation[1] is considered a common form of irregular rhythm and is probably the greatest cause of cardiac failure. If the condition persists, it results in dyspnea, edema, enlargement of the liver, ascites, albuminuria, pulmonary congestion and cyanosis, dependent upon which the ventricular chamber fails.

It is a disease that may occur at any age, but is found mostly in the rheumatic type during middle life, and is most frequent in the male in the ratio of 4:1, this being due to the greater physical activity of the male.

*Read before the Roanoke Academy of Medicine.

In the clinical groups[2] you will note:

(1) Rheumatic history	45.6%	
(2) Senile heart disease—coronary disease	21.4%	75.3%
(3) Thyrotoxicosis	4.0%	
(4) Hypertension	4.3%	

(5) Transient phenomena—thrombosis
(6) Acute infections—pneumonia, syphilis
(7) Miscellaneous:
  (a) Angioneurotic edema
  (b) Anesthesia
  (c) Toxic agents: Digitalis, nicotine, physostigmine.

In considering the physiological pathology, Lewis[3] noted that in cases of mitral stenosis the auricles are contracting during pre-systole with a regular rhythm with the sign of a mitral pre-systolic murmur; then, when the cardiac rate becomes irregular, the murmur disappears. This is explained by the fact that auricular systole is lost and the auricles are in a state of paralyzed diastole. This latter phenomena of absolute irregularity is the cessation of rhythmic beats from the pacemaker, the beats arising anywhere in the auricular musculature with rapid bombardment of impulses which strive to get through the A-V nodes. Due to the lack of uniformity of these impulses from an initial site, we get a gross, irregular rate of 350-600 beats at an irregular rhythm, all of which throws the auricular muscle into a state of quivering tetany with impure circus movements.

In seeing a patient with a cardiac irregularity the question of differential diagnosis arises, and we therefore consider the following:

(1) Sinus arrhythmia. Hold breath and see if you have slowing of heart rate and change in rate with respiration.
(2) Multiple premature beats
  (a) Disappear on exercise
  (b) Early cardiac contraction, followed by compensatory pause, longer than usual intervals between regular beats.
(3) Paroxysmal tachycardia
  (a) Not influenced by exercise
  (b) Not as rapid in rate (100-200)
  (c) Influenced by pressure on vagus nerve—rate slows.
(4) Auricular flutter
  (a) Is a pure circus movement (200-400)
  (b) If upon pressure of the vagus you inhibit the rate, upon counting rate before and after, note that the rate is halved. In flutter we find temporary change in ventricular rate. You never stop the flutter; it goes back after pressure stops.
  (c) Rapid steady heart under various circumstances.

After ruling out the above, our diagnosis is then based on the following facts:

(a) Rate—400-600 beats per minute.
(b) Impure circus movement.
(c) Gross irregularity of rate and rhythm.
(d) Pulse deficit—10 or more beats.
(e) Not influenced by respiratory changes.
(f) Exercise increases the rate. Rate increased by amyl nitrite or atropine.
(g) Not influenced by vagal stimulation other than the bringing out of the irregularity in rapid ventricular rates.
(h) Permanent as a rule—less paroxysmal.
(i) Organic mainly.
(k) The one condition that responds well to digitalis and quinidine.
(l) Electrocardiogram.

In the electrocardiographic[4, 5] examination we have an absolute aid in the diagnosis of auricular fibrillation. We note, as follows:

(1) Absence of P wave, showing lack of auricular contraction before the ventricular wave.

(2) We have a series of fff waves between the ventricular complexes. These waves vary in height, width and rate, and may appear like a P wave, but on close inspection we note their lack of uniformity and occurrence at a different interval before the ventricular level.

The fff waves of fibrillation depend mainly upon the same factors as the P wave. They are found large most often with hearts that have mitral stenosis (auricular hypertrophy) and small with hearts that have diffuse myocardial disease and are in poor condition.

We also note three different types[6] or forms in the electrocardiogram:

(1) Coarse type of wave with slow rate of circus movement, and seen when condition is recent or under quinidine. Rate 300-400.

(2) Fine type with high rate of circus movement (500-600) and seen in a fibrillation of long standing, particularly mitral stenosis. With digitali-

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zation the waves become finer and more rapid, but the ventricular responses become more regular.

(3) Auricular fibrillation with auriculo-ventricular block. The ventricular complexes may be regular, and we may get rapid rate of the latter (80-90) due to digitalis, but this is rare.

As you can see the electrocardiograph can give a great deal of clinical information in the correct handling of these patients. Occasionally we see a patient in whom the ventricular rate is 75 without the use of medication; these patients are thought to have a vagotonia or A-V system disturbed by disease.

When auricular fibrillation is present and the ventricles are perfectly regular, we know that complete heart block is present, and we know that digitalis would be contra-indicated, except in failure.

Telecardiographic examination as a rule will show these patients having a normal outline of their heart except in those cases where they have been of long existence, in which case the auricules become hypertrophied and later, as failure sets in, the ventricles hypertrophy. Fluoroscopically the irregularity is seen as the heart functions.

The question of prognosis[7] arises and the determination of which heart will do its best work to the demands of the circulation and what is the proper treatment.

When auricular fibrillation is long established it is usually permanent, although occasionally we have one that will revert to a normal rhythm. The prognosis likewise depends upon the severity of disease of the heart muscle and the amount of work with which it may be handicapped, such as valvular lesions or high blood pressure. The chronic forms usually are involved with a fibrotic process within the auricular muscle, but may have a good cardiac reserve sufficient to do most anything, providing the ventricles are in good condition.

A patient with a slow heart in similar cases is worse off than one with a fast rate because the fibrillator can be slowed and treated intelligently when the ventricular rate is fast.

The larger hearts with the same degree of failure have a worse prognosis.

The slower the reaction to drugs, the poorer the outlook and the more rapidly symptoms appear. An example is the patient who will clear up on rest in bed therapy presenting a good prognosis.

Change in rhythm may throw a patient into an acute emergency, such as a rheumatic mitral stenosis developing fibrillation with embolus.

A few patients with auricular fibrillation have a persistent tachycardia despite thorough digitalization as seen in thyrotoxicosis and acute injury to the myocardium from any cause. In these cases it is not the irregularity but the pulse deficit and the tachycardia which are harmful to the heart.

In one sense, auricular fibrillation is an asset[8] as compared to the insidious myocardial degeneration of other hearts with its regular rhythm. The reasons are:

(a) The tachycardia of auricular fibrillation is a common precipitating cause of heart failure, but this factor can be removed as a response to treatment.

(b) Digitalis is peculiarly fitted for the slowing down of arrhythmia to 60 or less beats per minute without toxic manifestations, whereas one cannot usually decrease the rate of a patient with regular rhythm to less than 70-80 beats without becoming toxic.

Patients are less likely to develop congestive failure between 50-60 rate than at a normal rate of 70-80. You can see the logic of this when you realize that a hypertrophied heart with a tachycardia requires a longer time to recover between beats, and that more oxygen is required to complete its task and the maintenance of an adequate blood supply to its own group of muscle fibers.

The cardiac output is increased 25 per cent upon proper digitalization, mainly when the cardiac rate is slowed and the pulse deficit eliminated. These patients will likewise show an increase in their vital capacity.

In rare cases of mitral stenosis and fibrillation there is formed free in the left auricle a ball thrombus which may cause sudden death.

As a group the fibrillators can be looked upon with optimism, the duration of life being from fifteen to thirty years, if properly handled.

In the treatment of this condition our two main drugs are digitalis and quinidine. Digitalis is the drug *par excellence:*

(1) It tends to increase the refractory period through its action on the auricles causing intra-auricular block.

(2) Its usual effect is to increase the rate and irregularity of its circus movement and to shorten its course by decreasing the refractory period through

carotid sinus and vagal action. The vagal action is greater than the muscular action.

Digitalis[9] is given when fibrillation is permanently established and should keep the heart slowed to 60 beats in order to prevent heart exhaustion from rapid ventricular beating. Now one may come in and see a patient who has been taking digitalis and note that the heart is apparently normal, regular; however, do not assume that the heart has ceased to fibrillate, as the ventricles may be beating with an idio-ventricular rhythm, the rate being controlled mainly from the junctional tissue, with a ventricular rate of 72, and probably an auricular rate of 400. You can have a partial block and this can only be checked with an electrocardiogram. Now if too much digitalis is given, we may get digitalis death, as shown with increased heart rate after digitalization. This is very rare.

A well-digitalized heart slowed down is better off irregular at 60 than regular at 80. A heart that has been complicated with embolic phenomena is better off with digitalis than by trying to make regular with quinidine, because a heart that has fibrillated a long time is apt to develop mural thrombi, due to stagnation of blood in the auricular appendages, and, if given quinidine, the resulting auricular muscular activity may cause bits of thrombi to be broken up and set free in the blood stream. Quinidine is given when the heart failure cannot be controlled by digitalis.

Quinidine is indicated, as a rule, in (1) fibrillations of recent origin. (2) No congestive failure, and (3) small heart. We hesitate to use this drug otherwise because there have been fatalities to its use.

Quinidine acts by (1) slowing the circus movement by increasing the refractory period of the auricular muscle, at the same time increasing the length of its circuit, this being necessary. (2) It depresses the vagus nerve and muscle.

Wenckebach (1914) showed that when quinidine is properly given, these patients may revert to a normal rhythm for weeks or months in at least two-thirds of the cases, and permanent fibrillation can be thus postponed from time to time.

It is best to observe patients who are receiving large doses of quinidine by keeping them in bed and checking with the electrocardiogram so that its toxic as well as its beneficial effects may be noted.

It is occasionally noted that fibrillation will occur as a complication of coronary thrombosis. As a rule, this will pass off, but, if persistent for ten days or more, it is well to give quinidine to break up this arrhythmia.

Following thyroidectomy in a patient having congestive heart failure there may follow the thyrotoxic crisis, and at this time auricular fibrillation will set in. In such cases quinidine will usually cause a reversion to the normal rhythm in a few hours; however, one should start out with a small dose to test the sensitivity of the patient. Auricular fibrillation when complicating thyrotoxicosis is less susceptible to digitalis and more reactive to quinidine.

Concerning other conditions, excitement and exertion will increase the heart rate in spite of digitalis, even more than is the case for normal rhythm.

Surgical operations and anesthesia should not be withheld. As you can well see, auricular fibrillation is one cardiac condition in which you can give the patient an optimistic mental and physical outlook on life and help make a useful member of society without being labeled a cardiac cripple and failure.

REFERENCES

1. Modern Methods of Treatment—Logan Clendening.
2.-6. Heart Disease—Paul D. White.
3.-4.-7. Clinical Aspects of the Electrocardiogram—Harold E. B. Pardee.
5. Disease of the Heart—Mackenzie.
8. Failure of the Circulation—T. R. Harrison.
9. Samuel A. Levine—Harvard Medical School.
Practice of Medicine—Tice, VI.
Diseases of the Chest—Norris and Landis.

Shenandoah Life Building.

New Members

Names of the doctors who have become members of the Medical Society of Virginia since the list published in the May, 1936, issue of the MONTHLY are:

Dr. Joseph Albert Abercrombie, Richlands.
Dr. Henry Louis Bastien, Arlington.
Dr. Paul Jette Bundy, Dante.
Dr. James Lawson Cabaniss, Roanoke.
Dr. Walter A. Carr, Harman.
Dr. Homer E. Clarke, Massies Mill.
Dr. Robert Henry Detwiler, Arlington.
Dr. Charles Howe Eller, Richmond.
Dr. William Penn Frazer, Hamilton.
Dr. Samuel Howard Garst, Staunton.
Dr. James Alfred Gooch, Alexandria.
Dr. Emanuel Greenspon, Newport News.
Dr. Charles Yeatman Griffith, Mount Holly.
Dr. Ray Huddle Grubbs, Christiansburg.

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Dr. Jabez P. Hankins, Orange.
Dr. Frank Hill Hedges, Richmond.
Dr. Edgar Wilson Kirby, Jr., Charlottesville.
Dr. Ralph Willis Jack, Farmville.
Dr. Clarence Porter Jones, Jr., Craigsville.
Dr. Andrew Matthews McLaughlin, Waynesboro.
Dr. Hugh Bennett Magill, Jr., Eastville.
Dr. Robert Mazet, Jr., Richmond.
Dr. Samuel Howard Mirmelstein, Newport News.
Dr. Clyde Garvice O'Brien, Appomattox.
Dr. Frederick Ralph Person, Williamsburg.
Dr. William Ribble Pretlow, Warrenton.
Dr. William Vincent Rucker, Bedford.
Dr. Jamie Pleasant Scott, Martinsville.
Dr. Randolph Beaton Turnbull, Sanatorium.
Dr. A. McGarvey Wallace, Gate City.
Dr. John Cheatham Wallace, Arlington.
Dr. Karl Kenneth Wallace, Norfolk.

Public Health Statistics

I. C. RIGGIN, M. D.
State Health Commissioner of Virginia

The communicable disease report received at the office of Dr. G. F. McGinnes, State Epidemiologist, for the month of August, 1936, shows the following cases compared with the same month in 1935:

	1936	*1935*
Typhoid and Paratyphoid	105	209
Diphtheria	49	100
Scarlet Fever	48	76
Measles	102	61
Meningitis	12	12
Poliomyelitis	18	277
Rocky Mountain Spotted Fever	20	12
Typhus Fever	1	1
Undulant Fever	5	4
Tularaemia	6	8
Smallpox	0	0

MEASLES

The much too prevalent attitude of triviality toward measles on the part not only of parents but also physicians and health officers is indeed unfortunate from a public health standpoint. The fact that the majority of measles cases have mild illnesses in comparison to some of the other communicable diseases and that the majority recover without complications or sequelae has led to a false feeling of security in regard to this disease in general. The impression that any attempt toward the control of measles under present conditions and with present knowledge is of little avail has caused the disease to be often ignored or neglected.

The fatality rate of measles usually varies between 0.5 and 1.0 per cent, but considering that an unknown number of deaths are attributed to the complications and not to the disease itself, the actual rate is probably even higher. The seriousness of the disease becomes apparent, however, when the fatality rates for specific age groups are considered. Though only a small proportion of the total measles cases occur in children under three years of age, approximately 50 per cent of all deaths occur in that small number of cases.

The case fatality rate in measles varies likewise with the physicial condition and nutritional state of the patient. Undernourished children and those already suffering from other disease fare badly with measles.

Though it is true that under present conditions it is practically impossible to prevent any individual who lives a normal life from developing measles sometime during life, it is also true that the disease can in some measure be limited to those age groups in which it will do the least harm, and that many of the serious consequences can be prevented.

Measles convalescent serum has proven very effective in preventing or modifying the typical course of a case of measles. If given within the first four days after initial exposure, a passive immunity is produced which lasts four to six weeks. A much more common practice, however, is to give the convalescent serum on the fifth or sixth day following exposure. In practically every instance the patient will develop a mild form of measles, recover without complications and will develop a life long immunity to the disease.

In children under two years, and those suffering from other disease or in such physical condition that measles would be hazardous to health or life, it is advised that the disease be prevented by giving the proper dosage of serum previous to the fifth day after exposure.

Normal adult serum, either pooled or from adults giving a history of measles at some time during life, has also proven of value; and likewise adult whole blood, though the dosage in this latter case is large—25 to 40 c.c., and for many reasons this method is not so satisfactory or effective as the use of convalescent serum.

McKhann has used placental extract to great advantage in the prevention and modification of measles. This immune globulin fraction has been recently used by several workers with promising results.

Reports for Sixty-seventh Annual Session of the Medical Society of Virginia

INTRODUCTORY NOTE

Reports to have the consideration of the House of Delegates at the sixty-seventh annual session of the Medical Society of Virginia in Staunton, October 13-15, are given below. Delegates and alternates are requested to read these carefully and be prepared to discuss and act upon the reports promptly when they are brought up by the President at the first meeting of the House. Chairmen may, of course, make supplementary reports where necessary, but much time will be saved for new business and for attendance upon scientific sessions if delegates consider these reports promptly.

The Council

MINUTES OF THE WINTER MEETING

The Council of the Medical Society of Virginia held its winter meeting at the Society's offices in Richmond, on February 5, 1936, at 2:00 P. M., with Dr. P. St. L. Moncure, president, of Norfolk, presiding. On account of the weather, several of the councilors were unable to attend. In addition to the president, those present were Dr. J. M. Hutcheson, Dr. J. L. Rawls, Dr. Roshier W. Miller, Dr. Wright Clarkson, and the secretary. Others sitting in the meeting and extended the privilege of the floor were Dr. F. S. Johns, Richmond, chairman of Legislation Committee, Dr. C. L. Harrell, Norfolk, and Dr. Guy R. Fisher, Staunton, chairman of the Committee of Arrangements for the Staunton meeting, Dr. Herbert C. Jones, Petersburg, and Dr. Beverley R. Tucker, Richmond.

Minutes of the Council meeting in Norfolk in October, 1935, were read and approved.

In view of an increase in revenue in the first four months, it was voted to allow the Publication Committee an additional $250.00 or as much thereof as necessary to be used on the journal, this being in accord with a resolution adopted in October.

The question as to the deed to the Walter Reed Home was brought up in the minutes and it was stated by the Secretary that Dr. Clarence Porter Jones, chairman of the Walter Reed Commission, had written that he would locate the deed and send it to the Society's office.

A statement was given each one present showing the financial condition of the Society at this time. The secretary-treasurer announced that Dr. F. H. Smith, retiring president, wrote that, as he was exempt from dues as an ex-president, he was sending the $5.00 he had been paying each year to be added to the Trust Fund for Post-Graduate Clinical Education, making the total at this time $20.38.

Dr. Miller stated that Dr. Beverley R. Tucker had presented a resolution before the Richmond Academy of Medicine with regard to certain legislative matters and asked that he be invited to come and present this to the Council. This request was granted and the invitation extended to Dr. Tucker.

In speaking of legislative matters, Dr. Jones said that the representative in the General Assembly from Petersburg is a man who wishes to be guided by organized medicine and could be counted on to help the doctors in matters pertaining to the medical profession. He wished to know about the hospital board proposed by the Governor and approved the suggestion of Dr. Johns that we try to have this board placed under the State Department of Health. He also spoke of the Hobson bill in Legislature for the establishment of a rehabilitation farm or sanatorium for those addicted to the use of alcohol or drugs that they might be segregated from the insane, this being a more humane handling of such cases.

Dr. Clarkson was the only councilor who had a special report to make. He stated that he had been working on a plan to have all counties in his district organize into the Fourth Congressional District Medical Society, this to replace the present Post-Graduate Medical Society of Southern Virginia. Upon his request, the Council approved the plan and moved that a charter be granted the new organization, when it had been completed, in accordance with the By-Laws. Motion carried.

Dr. Moncure stated that if the Council had no suggestions to make, the matter of arranging a program for the Health Division of the Virginia Conference on Social Work would be left entirely in the hands of Dr. W. P. Jackson, chairman of the Society's Committee to cooperate with that organization.

Upon suggestion of Dr. Fisher, October 13th, 14th, and 15th were selected as dates for the 1936 meeting of the Society in Saunton with headquarters at the Stonewall Jackson Hotel. Representing the Augusta County Medical Association, Dr. Fisher stated that the doctors and civic organizations of his city were much pleased that the Society is to meet in their city and they were planning entertainment for the visitors, which would perhaps include a barbecue for the members as well as entertainment for the ladies. Attention was called to the

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fact that the Council had voted several years ago that entertainments should be omitted at our annual meetings. In view of the fact that Dr. Fisher said the civic organizations wished to plan entertainment for the Society, however, it was decided to leave this matter in the hands of the local committee.

A letter was presented from Mr. Tufts in regard to handling the scientific exhibits for our meetings but it was deemed best to continue the plan which had been in force for several years of letting the local committee look after these and use the money received in defraying expenses of the meeting.

Dr. Tucker, who had arrived during the above discussion, was asked as to the resolution he had offered before the Richmond Academy of Medicine. He clarified the situation as to the General Hospital Board referred to in the Governor's message to Legislature, the additional appropriation for a new unit to the DeJarnette Sanatorium, Dr. Henry's bill as to the commitment of patients to State Hospitals, the Mental Hygiene Advisory Board for the State Penitentiary, and the new advisory board which he felt might replace this. Dr. Tucker then presented the following resolution:

> The Medical Society of Virginia, through its Council assembled, respectfully recommends to the Governor and to the General Assembly that the functions of the Governor's present Mental Hygiene Advisory Board for the State Penitentiary be enlarged to include, in an advisory capacity, legislative and appointive functions for the State hospitals and the feeble-minded and epileptic colony of the State of Virginia. We further request that the name of this board be changed to the Governor's Mental Hygiene Advisory Board for the State of Virginia and that the members constituting this board be recommended by the Medical Society of Virginia.

It was moved by Dr. Rawls, seconded by Dr. Clarkson, that this resolution be referred to Dr. Johns, chairman of the Legislative Committee, to handle as seemed best to his Committee.

A resolution received from the Ohio State Medical Association as to having all accredited American medical colleges requested to provide instruction for senior students on the activities, services and benefits of organized medicine was approved and the secretary was authorized to notify the deans of the two medical schools in Virginia in regard to this.

Dr. Jones, with the consent of the Council, then presented the following resolution:

> The Medical Society of Virginia, through its Council assesmbled, endorses the idea made in a bill authorizing the establishment of a farm or other suitable institution for the care of inebriates, apart from institutions for the care of the insane.

This was ordered referred to the Legislative Committee, to be properly drawn up and presented to Legislature.

A letter was read from the Philadelphia County Medical Society, stating that it is planned to invite the American Medical Association to hold its ninetieth annual meeting in Philadelphia in 1937, this being the year in which that city will commemorate its one hundred and fiftieth anniversary of the signing of the Constitution of the United States of America. It was deemed especially fitting to have the Association, which was founded in Philadelphia in 1847, meet there at the same time. Greater interest would be added to the occasion as two doctors were among the signers of the Constitution. The suggestion was ordered referred to our delegates to the A. M. A.

There being no further business, the meeting adjourned.

AGNES V. EDWARDS, *Secretary.*

Report of Delegates to the American Medical Association

As your representatives in the House of Delegates of the American Medical Association, we have the honor to submit this report:

The Annual Meeting of the Association this year was highly successful and our stay in Kansas City was delightful and instructive. As Virginians, however, we were particularly distressed at the illness of Doctor J. Tate Mason, a former Virginian, and president-elect of the American Medical Association. Because of his being too ill to attend the meeting, Doctor Mason was installed as president *in absentia* by special action of the House of Delegates.

In making his nominations for the standing committees, Doctor Mason honored one of us (J. C. Flippin) with an appointment to the Scientific Assembly. In his address which was read to the House of Delegates, Doctor Mason expressed surprise that the average American physician knows so little about the work that is being carried on at the headquarters of the American Medical Association, and suggested that each state send at its own expense a representative to Chicago for a week each year, to study and acquaint himself with the activities of the Association so that he may bring an idea of these home to the men of his state.

In the death of Doctor Mason, on June 20th, your delegates feel keenly the loss of a staunch friend and of a colleague who has rendered a great service to organized medicine.

Doctor Charles Gordon Heyd, professor of surgery, in the Post-Graduate Medical School of Columbia University, was elected vice-president, and under by-laws for the American Medical Association he has automatically assumed the duties of president. Doctor John Howell Janeway Upham, dean of the Medical School of Ohio State University, was elected president-elect. The Governor of Missouri and the Governor of Kansas attended the meeting in person and gave addresses of welcome.

Lord Horder, London, England; Leon Asher, Berne, Switzerland; and Walfang Heubner, Berlin, Germany, were distinguished foreign guests.

The House of Delegates adopted many important reso-

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lutions, the details of which may be found in *The Journal of the American Medical Association* under the dates of May 23rd and May 30th of this year. It would be impracticable to attempt a full account of all of these activities in this report, but the reading of these minutes in *The Journal of the American Medical Association* will be well worth the time of every physician in Virginia.

At this session, special attention was given to the relationship now existing between physicians and hospitals, to the question of raising further the standards of medical ethics, and of elevating further the standards of medical education.

The weather was ideal during the Kansas City session, the attendance was good, the scientific papers and the exhibits were excellent, and the various entertainments were impressive and were accompanied by a sense of good fellowship and exceptionally fine hospitality.

As your delegates, we wish to express to you our sincere appreciation for the privilege of representing the Medical Society of Virginia at this meeting, and finally we would like to emphasize the importance of further stimulating a widespread interest in the work of the American Medical Association among our members with the hope that the number of Fellowships from Virginia may be materially increased.

Respectfully submitted,

WRIGHT CLARKSON, *Chairman*,
J. C. FLIPPIN,
W. B. MARTIN.

Report of Executive Secretary-Treasurer

TO THE PRESIDENT AND MEMBERS OF THE HOUSE OF DELEGATES:

In addition to the Standing Committees named by Dr. Moncure when he took over the presidency of the Society last October, he named several Special Committees and all have been active as evidenced by reports published in this issue of the MONTHLY. We regret the death of three Committeemen—Dr. Southgate Leigh of the Advisory Board to the Woman's Auxiliary, Dr. H. T. Smith of the Legislative Committee and Dr. A. W. Hammond of the Membership Committee. It did not seem necessary to fill these vacancies until the annual meeting.

Mr. G. B. Zehmer, executive secretary of the Department of Clinical and Medical Education, is on leave of absence for a year and Mr. J. A. Rorer, also of the Extension Division of the University of Virginia, will be acting secretary in his absence.

As requested by the Council, Dr. C. P. Jones, chairman, has sent us the deed to the Walter Reed Home, and this is now filed in the Society's lock box.

The usual changes in membership have occurred with perhaps more deaths than in any one year for sometime. Figures will be given as of September 30th.

As ordered by the Council last year, charter was issued to Culpeper County Medical Society, making a total of fifty-three chartered societies including ninety counties and one city. Plans have not yet been completed for issuance of charter to the Fourth District Society which will replace the Post-Graduate Medical Society and include some additional counties. We regret again to report inactivity in some societies. However, this side is counterbalanced by reports of greater interest in other sections, notably, Dickenson-Buchanan County Society which recently re-organized and is holding monthly meetings.

Our regularly elected delegates, Dr. Wright Clarkson, Dr. J. C. Flippin, and Dr. Walter B. Martin, represented our Society at the meeting of the American Medical Association in Kansas City in May.

As is well known to the majority of our members, several years ago the Society advanced a sum of money to the publishers of the History of Medicine in Virginia to hasten the publication of the third volume of this splendid set of books. These are valuable and interesting and members of the Society who wish them should purchase the volumes promptly as the publishers advise that the supply on hand is limited and there will be no further editions.

The management at both The Homestead at Hot Springs and The Cavalier at Virginia Beach have written us with regard to our 1937 convention and have offered to do all possible for the success of our meeting should we select either resort.

Our financial status is good this year as will be evidenced by the auditor's report to appear with the minutes of our Staunton meeting. We have received several payments on the principal of the $1,000 bond held in trust since the depression which reduces the balance now due to $200. By instruction of the Finance Committee, we have invested $525 in United States Savings bonds which, if left to maturity, will in ten years yield $700 including interest.

Through the efforts of the chairman, Dr. F. H. Smith, as stated in his report, our trust fund for post-graduate clinical education has increased some this year and we suggest this as an excellent opportunity for free-will offerings.

A large amount of detail work has had the attention of our office and we wish to thank the members, committeemen, and officers who have cooperated with us in a splendid way.

AGNES V. EDWARDS,
Executive Secretary-Treasurer.

Report of Committee on Publication and Program

This Committee has held its usual meetings during the past year for the consideration of the affairs of the VIRGINIA MEDICAL MONTHLY and to plan the program of the annual meeting. We appreciate the increase in the appropriation allowed for the preparation of the journal and have used this in improving its appearance and in increasing the number of pages published in each issue.

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Changes made in the arrangement of this year's program will, we hope, increase the interest of the annual meeting.

H. B. MULHOLLAND,
H. A. TABB,
W. B. BLANTON, *Chairman.*

Report of the Committee on Scientific Exhibits and Clinics

MR. PRESIDENT AND MEMBERS OF THE HOUSE OF DELEGATES:

The members of the committee were notified October 25, 1936, of their appointment by the President of the Society, Dr. P. St. L. Moncure. Because past experience indicated the impossibility of making any progress until three or four months before the time for the meeting of the Society, the committee was relatively inactive. Since that time, however, attempts have been made to secure scientific exhibits from members of the Society and institutions in the State and elsewhere. Up to September 1, 1936, five very promising-looking exhibits had been secured. If past experience is an index, several additional exhibits, volunteered and solicited, should be secured for the meeting.

The Program Committee met July 31, 1936, and decided that, because of the difficulty of obtaining material, the usual Clinics would not be held this year.

The financial report this year is in keeping with better times. The committee acknowledges with thanks and appreciation an increase in appropriation by $25.00 last year, giving the committee $75.00 for its work this year. An attempt will be made to acquire some permanent equipment for the scientific exhibits and this policy, if followed, will eventually greatly improve the facilities available for the exhibitors. As in the past, the appropriation will be made available for the local chairman by the Executive Secretary of the Society to whom itemized expense accounts will be submitted.

The chairman of this committee, having completed two three-year terms as its chairman, wishes in retiring to thank the Society for the honor and privilege of serving in this capacity and to bespeak the same, hearty, continuing cooperation of the Society for succeeding chairmen.

The Committee again acknowledges with thanks the generous help of the Executive-Secretary of the Society, Miss Edwards, who has been of invaluable assistance in coordinating the work of the Committee.

Respectfully submitted,
W. AMBROSE MCGEE, M. D.,
J. D. WILLIS, M. D.,
C. BRUCE MORTON, M. D., *Chairman.*

Report of the Department of Clinical and Medical Education

The Department of Clinical and Medical Education can report little in the way of concrete achievements for the year ending in comparison with the achievements in previous years. It can, however, report significant progress.

The failure to report the continuation in any noteworthy degree of the post-graduate clinics and lectures and to show concrete results is due in part to financial difficulties. The last annual report showed a balance in the Department's funds of $9.91. The Society at its annual meeting, upon the recommendation of the Department, appropriated $500 for the continuation of the educational program. No further funds seemed available except those to be derived from attendance fees charged physicians who enrolled in the lecture-clinics sponsored by the Department. At best a budget of no more than $2,000 could be expected. Since this budget would not support a large program, the Department decided to concentrate its energies and resources on spring and summer programs since these appear to be the most suitable seasons for the kind of post-graduate work that has been emphasized. Accordingly no clinics or post-graduate programs were undertaken during the late fall and winter months.

Before spring arrived, however, there were possibilities that funds adequate to finance a rather extensive post-graduate program might be available. After investigating these possibilities, the Department concluded that funds were available, through cooperative measures to be taken with the State Department of Health, to provide for an indefinite period adequate for the full salary and travelling expenses of two graduate clinicians, one in the field of Obstetrics and Gynecology, the other in the field of Pediatrics. The scheme required that the Department provide the facilities and funds necessary for administering and supervising the work. In view of this possibility and the Department's approval of the plan of procedure, the Department concluded that it would be wise to forego the organization of independent clinics and to use its appropriations to take advantage of the two full-time clinicians for what seemed to be an assured two- or three-year program.

The Department is glad to report that during the late spring months plans were completed calling for the cooperation of the Bureau of Child Welfare of the United States Department of Labor, the State Department of Health, and the Medical Society of Virginia and providing for an indefinite period for two full-time clinicians who would work under the general direction and supervision of the Department. The plan was approved in principle and formally accepted by your Department, after careful and prolonged study and consideration, at a called meeting in Richmond on March 26, 1936.

The selection and appointment of Dr. L. L. Shamburger as post-graduate clinician in Obstetrics and Gynecology has already been reported in the columns of the VIRGINIA MEDICAL MONTHLY. Dr. Shamburger commenced his appointment on July 1st last. At the advice of the Department, he spent the first few weeks in visiting officials of the Department and of the Society and

physicians in strategic communities and sections of the State. At the request of the Medical Society of the city of Suffolk and of the counties of Isle of Wight and Nansemond, Dr. Shamburger then spent the three weeks beginning July 20th in these communities. No formal clinics or lectures were anticipated or planned. The procedure recommended and followed was that of informal meetings with physicians followed by informal visits, conferences and consultations when requested. One objective was to discover the most effective method for building upon the former work in Obstetrics carried on by Dr. M. E. Lapham. Dr. Shamburger reported that while in Suffolk, Isle of Wight and Nansemond, he met and was warmly greeted by all of the practicing physicians and that he held upon invitation one or more conferences or consultations with most of them.

Based upon the experience in these communities and acting especially upon the suggestions of the physicians whom Dr. Shamburger met and with whom he conferred, it was decided to attempt in other communities more formal lectures and clinics resembling somewhat the lecture-clinics conducted by Dr. Lapham and referred to above. After this plan was announced, requests for clinics came from the communities of South Boston in Halifax, Lawrenceville in Brunswick, and Emporia in Greensville Counties. A lecture circuit including these three centers was organized and lecture-clinics commenced the week of August 17th. This circuit is still in progress at the time of preparing this report so the enrollment and attendance figures will have to be given in the next annual report.

Already invitations have come for Dr. Shamburger to appear on the programs of the Clinch Valley Society that meets at Lebanon September 19th and the Southwest Medical Society that meets at Wytheville on September 24th-25th. These invitations have been accepted. Plans to arrange lecture-clinics in southwest Virginia immediately following these programs are under consideration.

The attempt to find a suitable and available graduate clinician in Pediatrics has not yet met with success. The special committee appointed by the Department to select this clinician, and consisting of Drs. J. C. Flippin and E. Lee Sutton, reports contacts with favorable candidates and that it expects to announce the appointment of the clinician in Pediatrics soon.

The Medical College of Virginia and the Department of Medicine of the University of Virginia continued to conduct, in cooperation with the Department of Clinical and Medical Education, graduate clinics at their respective centers to which all licensed physicians in the State are invited. The clinics conducted this year were well attended and practicing physicians expressed interest and approval of these opportunities for refreshing their memories and receiving reports on new techniques and medical discoveries. There follow summaries of the programs conducted during the year at each of the medical centers and names of physicians attending each.

The financial statement is also included below. Very few items, it will be observed, have been charged against the Department for this year. The executive agency of the Department reports, however, that a few items for expenses incurred in the organization of the proposed southwest clinics will be submitted later.

In conclusion, the Department wishes to reaffirm its approval of and faith in the cooperative program referred to above and worked out in cooperation with the Child Welfare Bureau of the U. S. Department of Labor and the Virginia State Department of Health. It requests the cooperation of component societies in bringing the lectures and clinics in Obstetrics and Gynecology and in Pediatrics to the physicians throughout the State. It requests also suggestions as to ways and means for making this post-graduate work better adapted to the needs of the practicing physicians and accordingly more effective in keeping the members of the Medical Society of Virginia informed of significant developments in the field of medicine.

The Department, furthermore, urgently recommends that the Society appropriate for the forthcoming year, 1936-37, the sum of $500.00, the amount appropriated to the Department for the year covered by this report, to carry forward not only the program outlined above but other types of graduate instruction in which members of the Society express an interest, and that seem expedient and practical to the committee in charge.

Committee
F. H. SMITH, *Chairman*
G. B. ZEHMER, *Executive Secretary*,
I. C. RIGGIN,
J. C. FLIPPIN,
LEE E. SUTTON,
G. F. SIMPSON,
H. C. HENRY.

MEDICAL COLLEGE OF VIRGINIA CLINICS

Program

Monday, April 6, 1936

Focal Infection and Elective Localization. Dr. Edward C. Rosenow, University of Minnesota, Rochester, Minn.

Tuesday, April 7, 1936

The Importance of Alveolar Infection in Focal Infections. Dr. Harry Bear.

The Importance of Tonsils and Nasal Accessory Sinuses in Focal Infection. Dr. Karl S. Blackwell.

Focal Infection and Eye Disease. Dr. Emory Hill.

Focal Infection and Chronic Arthritis. Dr. Donald M. Faulkner.

Focal Infection and Infections of the Genito-Urinary Tract. Dr. A. I. Dodson.

Focal Infection and Diseases of the Nervous System. Dr. L. S. Meriwether.

Focal Infection and Cardio Vascular Disease. Dr. William B. Porter.

Round Table Discussion of Symposium. Discussion led by Dr. Wm. B. Porter.

XUM

Tuesday Evening, April 7th

Streptococci in Relation to Diseases of the Nervous System. Dr. Edward C. Rosenow.

Physicians Attending

Dr. Carleton Moorman, Altavista.
Dr. John H. Bonner, Beaumont.
Dr. C. F. Manges, Blacksburg.
Dr. John C. White, Blackstone.
Dr. G. S. Fultz, Butterworth.
Dr. R. M. DeHart, Christiansburg.
Dr. J. A. Wright, Doswell.
Dr. H. W. Pritchett, Danville.
Dr. W. E. Jennings, Danville.
Dr. E. B. Robertson, Danville.
Dr. J. J. Neal, Danville.
Dr. L. D. Morgan, Gladys.
Dr. James D. Clements, Gloucester.
Dr. Thomas F. Gill, Richmond.
Dr. Irwin Rifkin, Richmond.
Dr. Walter A. Porter, Hillsville.
Dr. S. E. Gunn, Hopewell.
Dr. J. M. Habel, Jetersville.
Dr. T. B. Ely, Jonesville.
Dr. E. F. Younger, Lynchburg.
Dr. Clarence P. Jones, Newport News.
Dr. J. C. Cutler, Newport News.
Dr. B. L. Carleton, Newport News.
Dr. M. H. Bland, Norfolk.
Dr. F. J. Wright, Petersburg.
Dr. H. Davis, Roanoke.
Dr. J. R. Parker, Providence Forge.
Dr. G. B. Barrow, Staunton.
Dr. G. E. Stone, Staunton.
Dr. Marshall J. Payne, Staunton.
Dr. P. D. Johnston, Tazewell.
Dr. W. R. Pretlow, The Plains.
Dr. J. F. Thaxton, Tye River.
Dr. H. T. Hawkins, Waynesboro.
Dr. C. O. Dearmont, White Post.
Dr. A. R. Grant, Utica, N. Y.
Dr. C. F. Ridge, Thurmond, W. Va.
Dr. L. I. Hoke, Layland, W. Va.
Dr. W. E. Bundy, Minden, W. Va.
Dr. G. S. Barbee, Zebulon, N. C.
Dr. H. M. Brown, Greenville, N. C.
Dr. W. M. B. Brown, Greenville, N. C.
Dr. G. G. Dixon, Ayden, N. C.
Dr. W. F. Evans, Williamson, N. C.
Dr. W. A. Hoggard, Hertford, N. C.
Dr. L. M. Massey, Zebulon, N. C.
Dr. R. C. Miller, Gastonia, N. C.
Dr. J. E. Raby, Tarboro, N. C.
Dr. C. B. Robertson, Jackson, N. C.
Dr. D. M. Royal, Salemburg, N. C.
Dr. H. Royster, Tarboro, N. C.
Dr. F. W. Long, Roanoke Rapids, N. C.
Dr. R. L. Tomlinson, Wilson, N. C.
Dr. N. W. Ward, Greenville, N. C.
Dr. T. M. Watson, Greenville, N. C.
Dr. J. W. Wilkins, Mount Olive, N. C.
Dr. J. L. Winstead, Greenville, N. C.

THE SIXTH SAINT PHILIP HOSPITAL POST-GRADUATE CLINIC FOR NEGRO PHYSICIANS

The sixth Saint Philip Hospital Post-Graduate Clinic, sponsored by the Medical College of Virginia, was held June 15th to June 27th, inclusive. The course of instruction was presented by the departments of medicine, surgery, pediatrics, obstetrics and their sub-divisions. The type of instruction varied very little from that of the preceding clinics. Dr. Peter M. Murray, of New York City, was again the visiting lecturer, giving several talks on gynecological problems. Thirty-six Negro physicians were in attendance, twenty-seven from Virginia and nine from North Carolina. At the present time it seems very likely that the clinic will be presented again next year.

CLINICS AT UNIVERSITY OF VIRGINIA HOSPITAL

Program

Sixteenth Post-Graduate Clinic

Friday, November 15, 1935

Pregnancy and Hypertension. Dr. J. E. Wood.
Present-Day Treatment of Malignant Disease. Dr. V. W. Archer.
Indigestion. Dr. Staige D. Blackford.
Clinico-Pathological Conference. Dr. J. C. Flippin and Dr. James R. Cash.
Surgical Clinic. Dr. Carrington Williams, of Richmond, Virginia.
Ward Rounds and Round Table.

Physicians Attending

Dr. A. E. Turman, Richmond.
Dr. J. F. Thaxton, Tye River.
Dr. R. E. Booker, Lottsburg.
Dr. J. C. Coulter, Charlottesville.
Dr. H. G. Byrd, Louisa.
Dr. C. B. Fox, Monterey.
Dr. D. M. Kipps, Front Royal.
Dr. E. L. Grubbs, Front Royal.
Dr. W. O. Cox, St. Paul.
Dr. G. F. Simpson, Purcellville.
Dr. G. H. Musgrave, Leesburg.
Dr. H. L. Baptist, Ivy.
Dr. C. D. Bennett, Chatham.
Dr. Elizabeth B. Sherman, Front Royal.
Dr. O. W. Carper, Front Royal.
Dr. Anita Lotti, Charlottesville.
Dr. Glenn C. Campbell, Staunton.
Dr. C. P. Obenschain, Staunton.
Dr. G. R. Elliott, Orange.
Dr. C. M. Rice, Sweet Briar.
Dr. W. H. Turner, Round Hill.
Dr. Marshall J. Payne, Staunton.
Dr. J. E. Womack, Staunton.

Dr. H. J. Morton, Stuart's Draft
Dr. R. S. Griffith, Basic City.
Dr. W. A. Kyger, Free Union.
Dr. John E. Cole, Fredericksburg.
Dr. T. W. Dew, Fredericksburg.
Dr. Carroll H. Iden, Berryville.
Dr. W. O. Smith, Altavista.
Dr. Frank Tappan, Berryville.
Dr. C. O. Dearmont, White Post.
Dr. R. F. Weems, Harrisonburg.
Dr. B. L. Carleton, Newport News.
Dr. C. W. Scott, Newport News.
Dr. R. L. Page, Batesville.
Dr. Carrington Williams, Richmond.
Dr. William Walker, Scottsville.
Dr. J. F. Stover, Doe Hill.
Dr. C. E. Watson, Broadway.
Dr. L. G. Roberts, Moorman's River.
Dr. H. F. White, Fishersville.
Dr. Elizabeth Cole, Norfolk.
Dr. Ruth Mason Grigg, Petersburg.

Program

Seventeenth Post-Graduate Clinic

Friday, May 8, 1936

Neurological Clinic. Dr. D. C. Wilson.
Clinical Pathological Conference. Drs. J. C. Flippin and J. R. Cash.
Biliary Disease. Dr. Albert M. Snell of the Mayo Clinic.
Dermatological Clinic. Dr. D. C. Smith.
Oto-Laryngological Clinic. Dr. F. D. Woodward.
Orthopedic Clinic. Dr. R. V. Funsten.
Surgical Clinic. Dr. C. B. Morton.
Round Table Discussions.

Physicians Attending

Dr. R. R. Goad, Hillsville.
Dr. E. L. Grubbs, Front Royal.
Dr. D. M. Kipps, Front Royal.
Dr. W. O. Smith, Altavista.
Dr. J. W. Preston, Roanoke.
Dr. G. B. Barrow, Staunton.
Dr. John O. Hurt, Staunton.
Dr. J. F. Repass, Wytheville.
Dr. W. R. Culbertson, Norton.
Dr. H. E. Clarke, Massie's Mills.
Dr. J. F. Thaxton, Tye River.
Dr. B. A. Rice, Forest.
Dr. O. W. Carper, Front Royal.
Dr. N. M. Canter, Harrisonburg.
Dr. W. S. Ferguson, Lynchburg.
Dr. E. A. Harper, Lynchburg.
Dr. E. G. Scott, Lynchburg.
Dr. J. J. Waff, Shenandoah.
Dr. Carol Rice, Sweet Briar.
Dr. M. J. Payne, Staunton.
Dr. J. S. DeJarnette, Staunton.
Dr. Alex. Robertson, Staunton.
Dr. W. A. Murphy, Staunton.
Dr. C. D. Bennett, Chatham.
Dr. W. A. Kyger, Free Union.
Dr. O. N. Shelton, Orange.
Dr. H. S. Daniel, Louisa.
Dr. H. G. Byrd, Louisa.
Dr. Charles O. Dearmont, White Post.
Dr. E. D. Davis, Jr., Crozet.
Dr. C. H. Iden, Berryville.
Dr. H. L. Baptist, Ivy.
Dr. W. C. Archer, Waynesboro.
Dr. F. J. Wright, Petersburg.
Dr. J. Bolling Jones, Petersburg.
Dr. D. C. Mayes, Church Road.
Dr. B. F. Randolph, Arrington.
Dr. Charles Robins, Jr., Richmond.
Dr. L. T. Stoneburner, Jr., Richmond.
Dr. Anita Lotti, Charlottesville.
Dr. Dan O. Nichols, Charlottesville.
Dr. W. H. Turner, Round Hill.
Dr. G. R. Elliott, Orange.
Dr. John E. Cole, Fredericksburg.
Dr. T. W. Dew, Fredericksburg.
Dr. F. T. Cassiday, Fredericksburg.
Dr. H. C. McCoy, Gordonsville.
Dr. H. F. White, Fishersville.
Dr. C. W. Putney, Staunton.
Dr. I. M. Nuckols, Mt. Sidney.
Dr. L. G. Roberts, Moorman's River.
Dr. C. C. Canada, Staunton.
Dr. C. W. Rodgers, Staunton.
Dr. S. H. Garst, Staunton.
Dr. A. S. Graham, Richmond.
Dr. J. M. Hurt, Blackstone.
Dr. Percy Harris, Scottsville.
Dr. L. B. Newman, Hampton.
Dr. H. T. Chelf, Culpeper.
Dr. J. O. Mundy, Charlottesville.
Dr. T. E. Patteson, Ransons.

FINANCIAL STATEMENT

September 1, 1935—August 31, 1936

RECEIPTS

Balance on hand September 1, 1935	$ 9.91
Medical Society of Virginia	500.00
	$509.91

DISBURSEMENTS

Dr. F. H. Smith, traveling expenses, Abingdon to Richmond, to attend Department Meeting, March 6, 1936	$ 10.00
Dr. H. C. Henry, traveling expenses, Petersburg to Richmond, to attend Department Meeting, March 6, 1936	4.00
Dr. J. C. Flippin, traveling expenses, Charlottesville to Richmond, to attend Department Meeting, March 6, 1936	5.00

XUM

Extension Division, University, Virginia, refunds for following items:	
Trip, J. A. Rorer, to Richmond, Suffolk, Nansemond, Brunswick, Greensville, Hampton—July 11th and 15th: Meals $7.65, Hotel $2.50, Ferries, $2.25, Telephone $.60, Est. Mileage (515 @ .03) $15.45	28.45
Trips, J. A. Rorer, to Halifax, Lunenburg, Mecklenburg, Brunswick, Greensville—August 3th, 5th and 6th: Meals $6.20, Hotel $2.50, Telephone $.60, Service to car. $.75, Est. Mileage (725 miles @ .03) $21.75	47.25
Michie Company, printing announcements for Halifax, Brunswick and Greensville clinics	8.50
Postage	3.89
	$107.09
Balance on Hand	$402.82

Report of Legislation Committee

Your Committee has kept in touch with national medical affairs through our Senator, Mr. Carter Glass. We feel that Mr. Glass has rendered real service in the interest of the Medical Society of Virginia.

In legislative affairs of the State of Virginia, your Committee attempted to carry out the wishes of the Council of this Society and takes this opportunity to thank every member of the Society who responded when called upon.

This Committee has not put the Society to any expense during the past year.

The Committee would like to urge a more solid and enthusiastic support from the Medical Society of Virginia than has been given in the past. With an unselfish attitude from all its members, much could be done in Legislative affairs toward the advancement of medicine.

With regret, we report the death of one of our members, Dr. H. T. Smith of Independence, who was also a member of the General Assesmbly of Virginia.

FRANK S. JOHNS, *Chairman,*
ROBERT J. PAYNE.

Report of Committee on Medical Economics

The Committee on Medical Economics has had no matter brought to its attention during the past year that required action.

WALTER B. MARTIN, *Chairman.*

Report of Membership Committee

No applications for membership from doctors not affiliated with component scoieties have been received for attention of our Committee. Obituary notices have been prepared for those members of whose deaths we have learned and these have been published in the MONTHLY. One of our Committee, Dr. A. W. Hammond, was among those reported during the past year.

In recognition of his splendid service to our Society during his term of office, we take pleasure in proposing the name of our president, Dr. P. St. L. Moncure, for honorary membership in our organization.

ISAAC PEIRCE,
J. A. WHITE, *Chairman.*

Report of Committee on Ethics

Up to September 1st the Committee on Ethics has had no matter referred to it for consideration or action.

J. C. FLIPPIN, *Chairman.*

Report of the Advisory Board to the Woman's Auxiliary

It is a pleasure to report continued and growing interest in the activities and service of the State Auxiliary.

The Executive Committe submitted to the Advisory Board three recommendations for acquainting the public with the work of the doctors and interpreting it in carefully guarded statements intended to show the purposes of their scientific efforts for the benefit of humanity.

With the aid of local physicians, they hope to be of great benefit in preparing the public to understand and readily appreciate the value of the new scientific ideas as they are evolved, and make practical use of them.

For the present, the work will not be introduced into the Negro public schools as recommended by the Committee as there is so much danger of misconception of the aims of the profession, and all safeguards will be used to prevent this.

It is believed that the Auxiliary members can be of great service in extending the work of the physicians in this way.

J. ALLISON HODGES, *Chairman.*

Report of the Committee to Administer Trust Fund for Post-Graduate Clinical Education

This Committee is composed of the five ex-presidents last to hold office. It is set up in the organic law of the Society to administer the *earnings only* of any donation which may be made to the cause of post-graduate education. The Committee has been in existence six years, and yet the "Fund" available for "administration" is exactly 58c!

The Committee reports that this Fund by August 15, 1936 is intact. A total of $20.00 has been subscribed to the Fund and the proceeds of investment of this Fund at above date are 58c, a total of $20.58!

It is proper to remind ourselves that this Society has two committees the functions of which overlap in part—this Committee and the Department of Clinical Education. This Committee to Administer the Fund for Post-Graduate Clinical Education does not receive an appropriation, or allocation of funds from the Society's treasury, as the Department of Clinical Education does. On the other hand this present committee depends en-

tirely upon free-will donations to what it was hoped would grow into a sizeable fund, the earnings of which would carry on a worthwhile work.

This hope has not been realized, perhaps because of the economic conditions, perhaps because those who might have been interested have doubted the necessity of raising a trust fund for the very same purposes for which the Society is appropriating funds through another committee or department.

Recently another factor has arisen, namely, an appropriation of the Federal government, through the State Board of Health, which can be used for instruction of physicians under certain limitations. These Federal funds originate in the Social Security laws. At present they can be used only for instruction in Obstetrics as a part of the Maternal Welfare Campaign. Possibly we may be allowed to add Pediatrics as a part of the Child Welfare Program. At any rate, these funds are now available through the cooperation of the State Board of Health with two Medical Schools and the Medical Society of Virginia. So long as the Government continues this program, we may be able to keep a clinician constantly in the field, at a relatively small cost to the Medical Society of Virginia.

How long we can depend upon these governmental grants is unpredictable. Furthermore, post-graduate education will be quite lop-sided if it must be confined to Obstetrics and possibly Pediatrics. Hence, it seems to this Committee wise to continue to support our own program of post-graduate education as supplementary to that made possible by grants from the Government.

Therefore, the Committee to Administer the Fund for Post-Graduate Clinical Education has reached the conclusion that it should make a real effort to arouse interest in this fund and to solicit subscriptions or donations thereto. To this end we have proposed to all living ex-presidents that they donate each year the equivalent of the dues from which they are now excused when upon retiring from the presidency they were made honorary members of the Society. The response has been ready and hearty from eight of those still in active practice. They will subscribe to the fund at least $5.00 annually, though each reserves the right to discontinue this donation when he sees fit.*

Of course, this action of the ex-presidents is but a gesture, and a futile gesture, unless it stimulates a wide interest in this program and general subscriptions to the fund. Hence, the Committee will watch with interest the response by the members of the Medical Society.

We recommend, therefore, that this House of Delegates give thought to the present situation as it effects the whole problem of post-graduate education of Virginia physicians, to determine whether we should continue to function as in the past; whether there should be consolidation of these two Committees; and, if the Committee to Administer the Fund for Post-Graduate Clinical Education is to continue as an independent body, we ask that the House urge the Councilors to present this matter to the physicians of their several districts, appealing for general subscriptions to be made regularly to this fund.

F. H. SMITH, *Chairman*,
R. D. BATES,
J. C. FLIPPIN,
I. C. HARRISON.

NOTE: Dr. J. A. Hodges' name is not signed to report as he had not replied to time of going to press.

*The ex-presidents who promised contributions have been heard from and at date of publication, the fund amounts to $55.58.

Report of Committee on Child Welfare

TO THE HOUSE OF DELEGATES, MEDICAL SOCIETY OF VIRGINIA:

For the Child Welfare Committee consisting of Dr. L. T. Royster, Dr. F. D. Wilson, Dr. Chas. E. Conrad, Dr. R. D. Bates, Dr. J. B. Stone, Dr. P. W. Miles, and myself, I wish to make the following report:

It will be recalled that at the 1935 meeting of this body a report of the recommendations of the State Child's Conservation Committee was made. This Committee is composed of members of the Child Welfare Committee of the Medical Society of Virginia and members from the Virginia Tuberculosis Association, the Virginia Pediatric Society, the Virginia Parent-Teacher Association, the Virginia Education Association, the State Superintendents' Association, and the Virginia Federation of Women's Clubs.

In that report there were pointed out some specific health needs in Virginia and some specific amounts of money were recommended to be used for alleviation of at least a part of those needs. Specific departments were designated as considered the best for handling those amounts of money. This report was indorsed by the Medical Society of Virginia in its annual session last year and by all the other organizations represented on the joint Child Conservation Committee.

The report was then taken to the Governor, the State Budget Committee, and the State Finance and Appropriations Committee successively, with a request for favorable action by the Virginia General Assembly at its biennial session.

The different amounts recommended for the different departments were embodied in last year's report and will not be repeated here. Attention to that report is invited (see page 526, December, 1935, VIRGINIA MEDICAL MONTHLY). Of the total amount of $197,000 requested, only a very small part, about $10,500 was appropriated. That amount is to be used for increasing the number of free beds for tuberculosis patients and for the employment of an eye specialist in rural schools. The immediate net result of our achievements seems quite small, although the request was approved by all the organizations represented, and the need is urgent.

In spite of this discouraging report of immediate results we feel that much was accomplished educationally. This was done by informing the public generally of these

great needs through the year's intensive campaign of carrying the information to all sections of the State and to many groups of interested citizens. We think public interest in health protective measures has very definitely increased as a result of this joint campaign. We think also that continued effort of this kind by as many organizations as will cooperate must reflect in increased appropriations for such preventive work in the future and bring Virginia up to a more favorable position with regard to health protection and child care among the States of the Union than she now holds.

We are convinced that our recommendations are sound and are also convinced that any failure to reach a proper position in measures of health protection is a direct index of public attitude. Our legislators are our representatives and as such they desire to grant our requests as far as possible. If we bring sufficient support by a convinced public opinion they most likely will gladly accede to our wishes.

We feel that there is a great need for more health work in our schools which involves especially careful selection of teachers who are living examples of health and proper training of them in health conservation. It also requires continued effort, state-wide in nature, both in increasing the percentage of physically fit children entering school for the first time and also in increasing the amount and improving the quality of health teaching in our public schools. These last two items show very definite improvement in recent years, yet there is much left to be done if we believe as we do that health teaching ranks among the most important items of education.

There is also need for vigorous continued effort in trying to bring to and keep up to proper standards the living conditions in the homes and health service in our public schools.

For the immediate future it seems that the logical plan is to continue this educational program and continue to cooperate with the Bureau of Child Health of the State Department of Health in an advisory capacity. For the past several years this Bureau has striven as far as possible to carry out our recommendations. With this continued concerted effort we hope that still more interest in preventive health measures will be obtained and larger appropriations may be granted in the near future for this most important work.

Respectfully submitted,

W. P. JACKSON, *Chairman.*

Report of the Walter Reed Memorial Commission

Belroi, the birthplace of the Hero, Dr. Walter Reed, is in good physical condition. Dr. J. D. Clements of Ordinary, the local member of our Committee, attends promptly to any repairs, which thus far have been of a minor nature: the Gloucester Woman's Club has had supervision over the building and grounds since the restoration. The patriotic ladies deserve the sincere thanks of the Commission, as well as the profession, for this valuable service; by their zeal in the premises, we have been saved the expense of a caretaker's wage. The building is cleaned at regular intervals, the grass is cut several times each year. The visitors' register reveals many persons from a distance have entered the shrine to commune with the spirit of this great leader.

We will ask that the fire insurance protection be continued and that ten dollars additional to our last year's budget be placed in the hands of the treasurer of the Medical Society of Virginia for the coming year, that so much thereof as is needed may be used for repairs and cleaning of buildings and grounds. No expense of any nature is incurred in the premises without authorization from Dr. Clements.

A most desirable improvement would be a concrete walk from the highway to the front doorsteps. While the grass is not usually allowed to grow to any great height, there have been some pungent protests received from visiting ladies, especially from out of the State, that a damage has been done to shoes and hosiery from walking through "that stubble," as they term it. Other improvements would be building the log kitchen which was burned before we secured the property; also a permanent fence around the boundary of one acre. If some rich person would remember the shrine in his will for a modest sum and quickly pass on to his reward, it would help.

Respectfully submitted,

CLARENCE PORTER JONES, *Chairman.*

Report of Committee to Arrange Program for the Health Division of the Virginia Conference of Social Work

TO THE HOUSE OF DELEGATES, MEDICAL SOCIETY OF VIRGINIA:

As per request of your president, this committee arranged the program for the Health Division of the annual meeting of the Virginia Conference of Social Work which was held at Roanoke in March of this year. This section of the Conference held three sessions, each with a different theme. First, the "Social and Public Health Aspects of Venereal Diseases," second, "Medical Care for the Indigent Sick and Low Income Groups," and third, "Health Education and Methods of Appraising Local Health Needs and Facilities."

These subjects were well presented and ably discussed. It is to be regretted that not more physicians heard these discussions. At the last session the Findings Committee made the following recommendations:

REPORT AND RECOMMENDATIONS OF THE FINDINGS COMMITTEE OF THE DIVISION OF PUBLIC HEALTH AND MEDICAL CARE OF THE VIRGINIA CONFERENCE OF SOCIAL WORK, 1936

I. The Division on Public Health and Medical Care of the Virginia Conference of Social Work continues to endorse the recommendations of the Public Health Section of the 1935 Conference and recommends the continuation of efforts to carry out this report.

II. We also endorse the program and efforts of the State Health Commissioner to extend rural health work in Virginia.

III. We endorse the program of the Child Conservation Committee of Virginia and urge that every effort be made to promote its efforts toward the expansion of State and local programs for tuberculosis control, venereal disease control, sight-saving, immunization, tonsil and adenoid clinics, and other services for the indigent sick.

IV. We recommend that a continuing committee of the Medical Society of Virginia lend its efforts throughout the year toward the carrying out of these recommendations and we further recommend that this committee cooperate and coordinate its efforts wherever possible with those of the Child Conservation Committee and other committees working for improvement of State health problems.

V. We further recommend that this committee, in cooperation with other groups in the State, develop a program for the interpretation to and education of the community at large concerning health needs in the State, with the objective of creating public support for the development of adequate health programs throughout the State.

Committee { W. P. JACKSON, M. D., C. B. RANSONE, M. D., T. J. HUGHES, M. D., C. L. OUTLAND, M. D., B. B. BAGBY, M. D., R. W. GARNETT, M. D.

The Conference at its final business session voted to organize the Virginia Welfare Council. As many problems concerning public health and treatment of disease will doubtless be presented before the Council, it seemed advisable, and the Council requested, that one of its members be a representative from the Medical Society of Virginia. Therefore, subject to your approval, I recommend that a member of our Society be appointed to represent us in the proceedings of the Council.

In accordance with action by the House of Delegates at our 1935 session, the Medical Society of Virginia accepted the responsibility for sponsoring the program of the Health Division at each annual meeting of the Virginia Conference of Social Work and the president was empowered to appoint this committee.

Respectfully submitted,

W. P. JACKSON, *Chairman.*

Report of the Committee on Maternal Welfare

The Maternal Welfare Committee of the Medical Society of Virginia met on Sunday, May 3, 1936, in Richmond, Va.

Members of the Committee present were:

Dr. Greer Baughman, Richmond.
Dr. F. O. Plunkett, Lynchburg.
Dr. C. J. Andrews, Norfolk.
Dr. T. J. Williams, Chairman, University.

Also present at the meeting were the following obstetricians and gynecologists:

Dr. Joseph Bear, Richmond.
Dr. William Bickers, Richmond.
Dr. B. H. Gray, Richmond.
Dr. Harrison Picot, Richmond.
Dr. M. P. Rucker, Richmond.
Dr. H. S. Spalding, Richmond.
Dr. A. L. Stratford, Richmond.
Dr. W. D. Suggs, Richmond.
Dr. J. M. Whitfield, Richmond.
Dr. H. H. Ware, Jr., Richmond.
Dr. E. S. Groseclose, Lynchburg.
Dr. G. Bentley Byrd, Norfolk.
Dr. P. E. Thornhill, Norfolk.
Dr. M. B. Savage, Norfolk.
Dr. W. R. Payne, Newport News.
Dr. J. M. Nokes, University.

With this group as a nucleus, an obstetrical and gynecological society was organized to be known as the Virginia Obstetrical and Gynecological Society, whose object is to advance the study and practice of obstetrics and gynecology in the State of Virginia.

Dr. Williams as Chairman of the Committee read letters from Dr. Fred Adair, Chairman of the American Committee on Maternal Welfare, Inc., and Dr. I. C. Riggin, State Health Officer, concerning the plans of the National Committee for maternal welfare and post-graduate instruction under the provisions of the Social Security Legislation. The plans for a proposed post-graduate course of instruction in obstetrics in Virginia were freely and frankly discussed by the members of the Committee and by the members of the Virginia Obstetrical and Gynecological Society present. Considerable skepticism was expressed by the various discussants regarding the success of an exact duplication of the course given by Dr. Lapham a few years ago. It was the general feeling that the course should not be given in the same territory as that covered by Dr. Lapham, and that it should be given to smaller groups of physicians in the rural areas. The Committee agreed to cooperate in any possible way to secure the success of the course of instruction in obstetrics. Dr. Williams was instructed to convey the opinion of the Committee to the State Health Officer, and to cooperate with him in any way possible to secure the success of the post-graduate course.

The need for obstetrical papers on the program of the meeting of the State Society was discussed and Dr. Andrews was appointed to contact the program committee of the State Society in an effort to have an obstetrician of national reputation as an invited guest speaker of the Society at the fall meeting.

The meeting adjourned at 5:45 P. M.

Committee { T. J. WILLIAMS, JOHN O. BOYD, F. O. PLUNKETT, C. J. ANDREWS, GREER BAUGHMAN.

Woman's Auxiliary to the Medical Society of Va.

President—MRS. FLETCHER J. WRIGHT, 49 S. Market St., Petersburg.

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Our Staunton Meeting.

The fourteenth annual meeting of the Woman's Auxiliary to the Medical Society of Virginia will convene in Staunton, October 13th, 14th and 15th. An annual meeting of the Auxiliary is always an occasion to be eagerly anticipated and long remembered. It brings about the meeting of old friends and the making of new. It enables the members to learn what the "other half" of the auxiliary groups are accomplishing in various localities throughout the State, and how they do it. An annual meeting stimulates, it strengthens, and it spurs us on to greater achievements. It has been twelve years since Staunton has been the Convention City of the Medical Society of Virginia. Its picturesque location makes it an ideal selection, particularly so at this time with the newly opened Sykline Drive available. The birthplace of Dr. Ephriam McDowell nearby in Rockbridge County, not far from Lexington, should prove of particular interest to our Jane Todd Crawford Memorial Committee. A marker was placed at the site in 1928 by the Medical Society of Virginia.

A full and most interesting program, both business and social, has been prepared by the Program Committee. Dr. Moncure, President of the Medical Society of Virginia, has urged the doctors to bring "their better halves," stating that "the more women we have at these meetings, the more dignity we add to the occasion." Mrs. Wright, our own President, has urged that we adopt the slogan "SEE YOU IN STAUNTON" during the few remaining weeks. So plan now to go, and by *your* presence, make this the biggest and best meeting ever held.

Southern Medical Auxiliary.

The Woman's Auxiliary to the Southern Medical Association will hold its annual meeting in Baltimore, Md., November 17th to 20th. It is hoped that the State of Virginia will have a large representation in our neighboring city. Remember the dates, and try to arrange to attend.

Abstracts

Vacation Post-Graduate Cruise, Seaboard Medical Association of Virginia and North Carolina, S. S. Reliance, June 14-19, 1936.

(Continued from page 382.)

MECHANICAL DERANGEMENTS OF THE SEMILUNAR CARTILAGES OF THE KNEE

A. R. SHANDS, M. D., DURHAM, N. C.

Dr. Shands stated that injuries to the semilunar cartilages constitute 75 per cent of the internal derangements. He had operated 48 cases with a close follow-up for at least 6 months subsequent to operation, after each patient finished hospitalization. In addition, Dr. Shands gave his results in experimentation on dogs to observe regeneration of the semilunar cartilage. A major portion of these cases resulted from athletic endeavor especially football. An acute injury is rather difficult to diagnose because of generalized swelling, tenderness, etc. Knees are routinely X-rayed to rule out bone involvement. Conservative measures: rest in bed, physiothermy, diathermy, heating pad, massage and gradual active and passive motions as swelling subsides. When becoming ambulatory, use crutches and a dressing which allows for a certain amount of flexion and extension, but no lateral motion.

Following resumption of weight, if the cartilage has been injured there is felt by the patient a sensation of "slipping" and insecurity of the joint. Without apparent reason the knee "gives way," causing one to fall to the ground,—usually sharp stabbing pain. Upon arising he may not be able to straighten knee or move joint,—complete or partial locking. In such as instance the removal of the cartilage is the correct procedure.

As soon as operative wound heals a moulded leather knee brace, modification of the Jones knee cage, should be worn for six to eighteen months.

Of the forty-eight cases, thirty-five were males, thirteen females, youngest fifteen, oldest forty-three years; average age 23.4 years. The right knee was

affected sixteen times, left knee thirty-two. Thirty-seven cases occurred in the sports, five in industry and six in miscellaneous accidents.

Results were, thirty-four good, nine, fair, four, poor, one, questionable. Thirty of the cases returned to the sports after operation.

Dr. Shands reported the result of removing semilunar cartilage from dogs' knees,—eight cases studied. The dogs were sacrificed and regeneration of the cartilage was definitely a fact.

The outstanding facts evident in the study of forty-eight cases semilunar cartilage injury are:

1. Seventy-seven per cent occurred in sports.

2. All except two before operation complained of pain, slipping, giving away or catching, and swelling of the joint, and all except eight had episodes of complete or partial locking.

3. Forty-six, or ninety-six per cent, before operation had definite tenderness over the affected cartilage, fifty per cent had limitation of extension. Two had a definite palpable mass over the affected cartilage.

4. There are six times as many internal cartilages affected as external. Fifty per cent had an anterior third fracture of the cartilage and sixteen or thirty-two per cent were bucket-handle fractures. An average of eighty-eight per cent of the cartilage was removed.

5. After operative removal of the cartilage or cartilages there are seventy-one per cent good results, and sixty-nine per cent expressing complete satisfaction with the result. Sixty-one per cent engaged in sports after operation. In forty per cent the operative knee is as good as the normal knee.

6. Pain is the outstanding postoperative complaint in fifty per cent and weakness and limitation of motion is present in twenty-nine per cent.

7. Removal of the semilunar cartilage with a mechanical derangement is a well justified procedure.

8. The semilunar cartilage does definitely regenerate after removal in a dog's knee.

TUBERCULOSIS IN INFANCY AND CHILDHOOD

JAMES B. SIDBURY, M. D., WILMINGTON, N. C.

Tuberculosis in infancy is preventable. A child should not nurse a tuberculous mother; to do so it signs its own death warrant. The mother may have a chronic cough not malignant to her, but fatal to the child. No woman, relative, servant or anyone with a cough should be allowed to care for a child. Those who have had a slight cough for ten years or so, who seem to be in excellent health, yet spraying the infection all around and over the child, are the hardest persons to convince of their danger, and are the most resentful and malignantly spiteful to the doctor when he does his imperative duty in informing them they must not handle or go near a young child. Tuberculosis is insidious in children. The child may have the focus implanted and be years developing into an active lesion. The responsibility rests with the physician. Every child should be given a thorough examination. Every tooth, his tonsils, adenoids and sinuses should be checked over; and if there is still afternoon depression or fever, make a tuberculin test; if this is negative look further. If positive take an X-ray picture; from four to eight per cent give negative tests when there is tuberculosis; therefore, "one swallow does not make a summer." All children are born with tuberculosis; if there is not tubercular contact to hinder the child till he is five years old, he will have by his own resistance cured himself of the focus at birth, but will have established a resistance to the disease which is well nigh impenetrable. It is not one focus which is the dangerous item; but the continued re-infecting the child, many times a day by the contact's sputum in fine droplets in the atmosphere of the room, which bears down on the child's natural resistance and overcomes it. Tests by tuberculin and X-ray combined will reveal that there is an active focus, or has been an active focus sufficient to have left a scar or scars, ten per cent in infants one year old; thirty per cent in persons ten years old, and ninety per cent in persons thirty years old. After finding active tuberculosis, every member of the family, every servant should be examined and tested to find the carrier-contact. We are missing lots of cases of easily curable tuberculosis by not having a universal X-ray study of all young children. Many children who have active tuberculosis are over-weight. The tendency in all infants is to recover if the contacts are kept away (i.e., all persons who cough fresh germs around the vicinity of the child several times a day). Fortunate is the group of young children, often, for the mother to die. For so many devoted mothers can not be made to see the importance of not coughing around, kissing and fondling the children.

People are educated to have pigs, cows and sheep tested regularly for tuberculosis but have to be urged, and re-urged to have their children tested; at

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the same time many more children have tuberculosis in proportion than domestic animals.

SUNSHINE RASH AND PELLAGRA

JULIAN M. RUFFIN, M. D., DURHAM, N. C.

Dr. Ruffin in his able address reviewed the literature accumulated on the relationship between exposure to sunlight and the development of skin lesions in pellagra. He also related the results of an investigation during the last four years in conjunction with Dr. David T. Smith and others at the Duke Hospital to determine which of the conflicting views seemed to be more promising to solve the matter of etiology. There were 134 cases studied, each case being admitted to the hospital; there were varying degrees of morbidity, a number being desperately ill on admission; six of the latter died shortly after admission. Autopsy carefully made in these six revealed no pathology except that which would be found in marked anaemia. The study of the nervous tissues as well as the gastro-intestinal mucosa microscopically revealed no pathology. On hospitalization these patients were prevented from exposure to sun's rays and any other form of strong heat; they were placed on a basic diet with adequate vitamins, minerals, proteins, fats and carbohydrates with the exception of the P-P factor of Goldberger. Dr. Ruffin said in response to a question that the diet was the normal Duke Hospital diet with a more liberal allowance of red meats, eggs, milk and green vegetables. The dermatitis described varied from an erythema with vesiculation to heavily crusted, indurated lesions, and was indistinguishable from the skin lesions of spontaneous pellagra. These cases, except the very ill ones, made a more or less rapid recovery; however, all recovered except the six previously mentioned.

A spectacular feature in this series was that after the patients were free of symptoms and still remained on the basic diet, skin lesions with return of sore tongue and gastro-intestinal symptoms recurred when these patients were exposed to the sun for a period of thirty minutes a day for four or five days. At each time a control was also subjected to the same exposure. Each patient leaving the hospital who kept on the basic diet and did not expose his body, hands, arms, face, etc., to sunlight or other sources of intense heat remained well. Several such cases returned who had disregarded this injunction, and on leaving the hospital the second time profited by their sad experience and kept well. Dr. Ruffin said that in former days when women wore sunbonnets which amply protected the face from direct sunlight, and wore stockings and gloves to the finger tips, they did not have pellagra. He also stated that pellagra is lowest in incidence in December and highest in June. One of the cases studied was that of a typical rash on hands and arms with the other symptoms in a worker exposed to heat rays, as iron worker. He also confirmed a question asked, that infra-red rays will provoke an attack of pellagra in a susceptible person. Yet, with the many illustrated slides and case histories, one is forced to conclude that pellagra is a deficiency disease due primarily to an unbalanced diet, in a person susceptible (which he terms a "pellagrin") and an allergic reaction to sunlight (or other forms of intense heat). He noticed that many pellagrins have disordered glands on the skin of the face, especially near the nostrils and on the forehead (blackheads, etc.).

The reactions which occur after a pellagrin in the deficient diet state exposes himself to the sun are dramatic in onset, alarming in severity, and not infrequently fatal. The usual story is that the patient subsisting upon a deficient diet, with vague symptoms, though still able to work, exposes himself to the direct rays of the sun during early spring and summer. Within a few hours a burning and itching sensation is noted over the exposed areas. This is followed twenty-four to thirty-six hours later by a fiery red erythematous rash. Vesiculation appears, accompanied by induration, dry crusts or secondary infection. The bright red erythema changes to a dull bronze and finally to a deep brown. Following the initial erythema, the mouth and tongue become red and sore and a diarrhoea appears. Dementia may develop without warning and is always an ominous sign.

From the study of the cases as narrated by Dr. Ruffin, one is forced to conclude that a pellagrin is seasonally subjected to pellagra if he is deficient in his diet habits and exposes himself to the intensity of solar radiation; and whether pellagra is an entity or syndrome, it is a proven fact that exposure of a susceptible individual subsisting upon a deficient diet to the sun's rays precipates the acute manifestations of pellagra.

CLARENCE PORTER JONES, M. D.,
Secretary.

(To be continued)

Truth About Medicine

New and Nonofficial Remedies

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

Gas Gangrene Antitoxin.—An anaerobic antitoxin (New and Nonofficial Remedies, 1936, p. 360) prepared from the serum of horses which have been immunized against the toxins of *Cl. Welchii* (perfringens) and *Cl. oedematis-maligni* (vibrion septique). It is marketed in packages of one vial containing 10,000 units of Clostridium Welchii antitoxin and 10,000 units of Clostridium oedematis-maligni antitoxin. E. R. Squibb & Sons, New York, N. Y.

Tetanus-Gas Gangrene Antitoxin.—An anaerobic antitoxin (New and Nonofficial Remedies, 1936, p. 360) prepared from the serum of horses which have been immunized against the toxins of *Cl. tetani* (tetanus), *Cl. Welchii* (perfringens), and *Cl. oedematis-maligni* (vibrion septique). It is marketed in packages of one syringe containing 1,500 units of Clostridium tetani antitoxin, 2,000 units of Clostridium Welchii antitoxin, and 2,000 units of Clostridium oedematis-maligni antitoxin. E. R. Squibb & Sons, New York, N. Y. (*J. A. M. A.*, August 1, 1936, p. 354.)

Propaganda for Reform

Foods for Weight Reduction.—The Council on Foods reports that it is now possible to plan for the person whose natural tendency is to eat beyond his caloric requirements a diet which will enable him to burn accumulated body fat and at the same time protect him from the dangers of undernutrition. A reducing diet is most successful when it differs radically from the individual's eating habits. The natural foods of which such a diet principally ought to be composed are skimmed milk, leafy vegetables prepared without fat of any kind, fruits without added sugar, and lean meats. In addition, vitamins A and B_1 must be supplied in concentrated form. Under circumstances such that the foods named are obtainable with difficulty, special foods of low energy value may be used to enrich the reducing diet in protein, minerals and vitamins. It is important that the contributions to the day's diet made by any so-called reducing food be clearly indicated. If the product is intended to replace one or two meals a day, suitable suggestions for the other meal or meals should be made. The advertising also should carry a statement that dieting to reduce is not without certain dangers, and it should be undertaken only under medical guidance. Foods intended as adjuncts to restricted diets will be accepted under the category of special purpose foods, with the restrictions as to advertising which apply to Special Purpose Foods, provided always that the name of the preparation is accompanied, wherever it appears on the label or advertising, by the statement "Food Supplement for a Reducing Diet." (*J. A. M. A.*, August 8, 1936, p. 431.)

Book Announcements

Bewildered Patients. By MARIAN S. NEWCOMER, M. D. Hale, Cushman & Flint. Boston. 1936. Octavo of xvi-323 pages. Cloth. Price, $1.75.

Undoubtedly within the covers of this book is found advice on many subjects of help to patients and prospective patients of doctors. Nevertheless, the extraneous matter, the somewhat technical description of certain phases of anatomy and physiology, and the author's attitude toward the reader as disclosed by the style of writing interfere with the benefits which otherwise might be derived from this educational treatise. There is too much of an attitude of adult to child instruction for it to make the appeal it deserves in so far as subject matter is concerned. WILLIAM R. JORDAN, M. D.

Arthritis and Rheumatic Disease. By MAURICE F. LAUTMAN, M. D., Consultant to the United States Public Health Service Clinic and Director of the Department for the Study of Arthritis, Levi Memorial Hospital, Hot Springs, Arkansas. With a Foreword by MORRIS FISHBEIN, M. D., Editor, *Journal of the American Medical Association*. New York. Whittlesey House. McGraw-Hill Book Company, Inc. 1936. Octavo of xxii-177 pages. Illustrated. Cloth. Price, $2.00.

The author states that "the main purpose of this book is to give the patient who is *threatened* with arthritis or who is already suffering from the disease sufficient information pertaining to the cause and treatment of his trouble to enable him to determine whether or not the treatment which he is receiving is adequate and intelligent, and to place him in a better position to judge whether or not he is making favorable progress." When one considers the variability of the course of arthritis and the controversies that have been waged both over the etiology and treatment of this disease, one must wonder if the author has not undertaken an impossible task. At any rate it is the reviewer's opinion that this book will not fulfill the aims of the writer.

The book discusses the etiology, symptoms and treatment of arthritis with particular reference to diet and physiotherapy. As a whole it is well written, yet, it is doubtful if the average practitioner by reading this book will learn much of a practical value that is not already generally known.

HARRY WALKER, M. D.

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Editorial

A Centenary Worth Celebrating.

Although the Army Medical Library was founded one hundred years ago it was not until after the Civil War that it received the impetus which placed it in its unique position as the world's greatest medical library. General Joseph K. Barnes was surgeon general at that time. Finding himself in the possession of an impressive fund which was no longer needed for the purchase of diets and necessities for the sick of the army, General Barnes saw to it that $80,000 was allotted to the improvement of the Army Medical Library. General John Shaw Billings was made Librarian, and Congress was induced to begin its annual Library appropriations. With money and Billings the Library grew by leaps and bounds. Rare books were cheap in Europe at that time and the Librarian bought lavishly. At the same time he spared no pains to build up the periodical literature of the Library. The preparation of an index catalogue, now including some forty-five large volumes, was begun, followed by the *Index Medicus*, a monthly index of all new medical books and articles published in the world. Now known as the *Quarterly Cumulative Index Medicus* of *The Journal of the American Medical Association*, it is more directly in the hands of organized medicine. There is nothing in the world in their field to equal these two publications of the Army Library, offering as they do access to a vast medical literature numbering hundreds of thousands of books and more than a million pamphlets and articles.

On November 16 the one hundredth anniversary of this great American Medical Institution will be observed with proper ceremonies in the Library building in Washington.

In Defense of Allergy.

There are probably many readers of the *Atlantic Monthly* who read with an appreciative chuckle a contribution to the Contributor's Club of the July issue of that magazine, entitled *Allergy*. The anonymous author might have given it the subtitle "The allergic Mrs. Werfel suffers at the hands of the allergist Dr. Wattle."

"Expectantly," so runs the account, this allergist "produced his tray of concentrated poisons, two hundred vials containing such deadly extracts as those of the soybean, the dill pickle, kohl-rabi, nutmeg, and canary feathers. Expectantly, with his tiny flat instrument, he coerced one hundred varying substances into each of Mrs. Werfel's arms. At the end of the two hours which the operation consumed, her arms bloomed like the rose, but with hives."

Cheerfully Mrs. Werfel was told "that she was intolerant to barley, oats, wheat, buckwheat, casaba, rice, cocoa, coffee, tea, tobacco, artichoke (French), artichoke (Jerusalem), asparagus, the navy bean, beet, broccoli, Brussels sprouts, not to mention

chives, corn, cottonseed, cucumber, dandelion, parsley, parsnips, peas, pimento, potato, pumpkin, as well as garlic, ginger, hops, malt, mustard, nutmeg, paprika, peppers, psyllium seed, sage, senna—as time went on she dozed, missing the fruit, the fish, the nut, the fabric, the feathers, the powder, the bacillus classes," and cheerfully she was instructed to confine her diet to "butter, heavy cream, goat milk, Parmesan cheese, egg white, duck egg, goose egg, gelatin, pork, rabbit, fig, lemon, butterfish, butternut."

When jaundice reduced this diet to the starvation proportions of gelatin and butternut, Dr. Wattle came to the rescue with "a really miraculous serum," which he assured her would make future dieting completely unnecessary, if she would be patient, for it naturally took time for the system to be "properly stabilized."

For three years he juggled the dosage for "extreme stimulation or extreme depression followed if the amount administered was too large or too small," and "the physician could only judge from the patient's reports," and when Mrs. Werfel was ready to jump off a bridge, Dr. Wattle was ready to save her with "the perfect diet, the diet that does away with all serums, the fat-free diet."

"But," said the now completely bewildered Mrs. Werfel, "I thought butter and cream, according to the skin tests, . . ."

"Skin tests," observed Dr. Wattle, "served their purpose for a time, but we have since discovered them to be misleading. The fat-free diet, on the other hand, is universal. Moreover, you must remember, that there is a certain type of allergy. . . ."

At the risk of being considered utterly devoid of humor for treating seriously such a delightful exercise in the art of poking fun, it should be said in all fairness that this is not the true picture of allergy in the hands of the true allergist, though it may be the true picture of allergy in the hands of the professional racketeer. Forty years ago all specialization had to run the gauntlet of this same type of criticism and offered the same kind of temptation to unscrupulous men. Fortunately the future of allergy is in the hands of broad gauge, scientifically trained men, and allergy clinics such as those conducted by Rackemann at the Massachusetts General Hospital, Cooke at the Roosevelt Hospital, and Gay at the Johns Hopkins Hospital are placing the specialty upon a sound and useful basis, in which the parade of innumerable skin tests plays but a minor role. The solution of allergic problems requires the keenest clinical acumen, the assistance of other specialists, and a minimum of reliance upon public-impressing manoeuvres.

Public Enemy No. 1.

We are told that the incidence of syphilis in the United States is fifty times greater than in the Scandinavian countries and that our morbidity rates remain stationary while those for Norway, Sweden, Denmark and Great Britain have been enormously reduced in recent years. We think we know why this is and we think we know what to do about it. The first step has been taken in ending the conspiracy of silence in regard to the disease. Syphilis is now being talked and written about under its own name. Newspapers are no longer afraid to print the word, and "nice people" are no longer ashamed to speak it. It stalks our stages as it stalks our land. It was recently noted at a performance of *Dead End* in New York City that between acts the audience talked of the syphilitic infection of one of the characters in the play more freely than had the actors themselves.

In the writing and talking about syphilis which now seems to be sanctioned by public opinion, the public is learning some astonishing facts about the disease. Our Surgeon General, Dr. Parran, makes out for them a serious case in his recent article in the widely read *Reader's Digest*. He tells them, for example, that one out of every ten adults contracts the disease, that seventeen cases were recently traced to a single party where a kissing game was played, that the incidence of venereal disease in several New York high schools has been so high in the last few years that the local authorities had to appeal for state aid in its control.

Not only must the public be told about the frequency of the disease and made familiar with the ways by which it is contracted, but fresh emphasis must be laid on its consequences. Few laymen know, for example, that 10 per cent of insanity and 18 per cent of cardiac diseases are directly due to syphilis. Most effective, however, in their enlightenment will be, not scare heads, but informative announcements in newspapers, public squares, everywhere, of the facts about treatment, where proper treatment can be had at little or no expense and the vital importance of early treatment. The dis-

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ease is 86 per cent curable in its early stages, whereas less than one-half respond when long neglected.

Publicity in regard to syphilis needs to reach philanthropists and legislators as well as its victims, potential and actual. It should be known that arsphenamin renders cases non-infectious, that syphilis is more eradicable than malaria or poliomyelitis, that treatment of a case of syphilis is only one-fifth as expensive as the treatment of a case of tuberculosis. Parran claims that syphilis can be eradicated for what has been spent on the control of one animal disease alone.

Whatever we think of methods of prevention and cure it seems now agreed that syphilis is Public Enemy No. 1, and as such it must be eradicated.

A Presidential Candidate's View of Medicine.

The socialization of medicine which many physicians have recognized as a part of the social legislation of the New Deal has been little talked of during recent months. One can be sure, however, that this is a sleeping and not a dead issue. When the November elections are over there is the possibility that Senator Wagner, Miss Perkins and Mr. Sydenstricker's successor will again put their heads together to evolve further social legislation for the control and regulation of medicine. We feel that we know the attitude of the present administration toward medicine. Over against this it is interesting to weigh the words of a presidential candidate who appears to speak the language of organized medicine. At the last meeting of the American Medical Association in Kansas City, Governor Alfred M. Landon is said to have told a large and enthusiastic audience that "Medicine will not willingly be made the servile instrument of politicians or the instrument of domineering bureaucracy. I predict," he continued, "that the typical American physician and organized medicine as a whole will at no time be ready for any scheme of regimentation, for any system of impersonalized medicine which is totally alien to the best traditions of the American practitioner and of the profession as a whole.

"The American practitioner will not be a party to destruction of that individual, personal service which has been the occasion of a special and justifiable pride." Whatever further advances are made in the broadening of medical service—and there will be an abundance of them—will be made, so far as he is concerned, in accordance with the fundamental conditions of previous achievements.

Proceedings of Societies

The Dickenson-Buchanan County Medical Society

Was re-organized August 7th, at Haysi, Va., and now has a membership of eighteen. At this time, Dr. A. S. Richardson, Grundy, was elected president; Dr. J. C. Moore, Clintwood, vice-president; and Dr. T. C. Sutherland, Haysi, secretary-treasurer. The second meeting was held at Grundy on September 11th, and was very interesting and informative. At this time, delegates and alternates to the State meeting in Staunton were elected. The next meeting will be held at Clintwood on October 6th.

The Loudoun County Medical Society

Held a special meeting on the evening of August 21st, at the home of its secretary, Dr. W. O. Bailey in Aldie, Va. At this meeting, addresses were made by Dr. P. St. L. Moncure of Norfolk, president, and Dr. J. Morrison Hutcheson of Richmond, president-elect of the Medical Society of Virginia. Dr. Charles S. White and Dr. William J. Mallory, both of Washington, gave interesting talks also. There were about sixty-five people in attendance, including physicians from Culpeper, Arlington, Fairfax, Loudoun, Prince William and Fauquier Counties.

Halifax County Medical Society.

At the annual meeting of this Society, the following officers were elected for the ensuing year: President, Dr. D. C. Steelsmith, South Boston; vice-president, Dr. C. B. White, Halifax; and secretary-treasurer, Dr. Wm. C. Brann (re-elected), South Boston.

The Lynchburg Academy of Medicine

Met in regular meeting in Lynchburg, Va., on September 14th, at which time Drs. Sam Wilson, E. A. Harper, and F. R. Hopkins, local pediatricians, presented a symposium under the general title of "Urinary Infections in Children." At the busi-

ness session, Dr. Clyde G. O'Brien of Appomattox, Dr. Geo. Robt. Carpenter of Brookneal, Dr. James Paul Kent of Altavista, and Dr. Carol Margaret Rice of Sweet Briar, were elected to active membership.

Dr. J. Henry Rawlings and Dr. John Hundley, Jr., both of Lynchburg, are president and secretary-treasurer, respectively, of this Society.

The Southside Virginia Medical Association

Held its regular quarterly meeting at Piedmont Sanatorium, Burkeville, Va., on September 8th. Papers were presented by Dr. Rudolph C. Thomason, Dr. Harrison Picot, Dr. Walter L. Nalls, and Dr. Marshall P. Gordon, all of Richmond, and Dr. John A. Proffitt, Burkeville. Following the meeting, dinner was served for the members and guests in the Staff dining-room of the hospital.

Dr. L. S. Early, Petersburg, is president of this Association, and Dr. R. L. Raiford, Franklin, executive secretary-treasurer.

News Notes

All Roads Lead to Staunton—

And they are good ones—for the sixty-seventh annual meeting of the Medical Society of Virginia. The dates are October 13th, 14th and 15th, a lovely season to spend a few days in the Virginia mountains, so why not pack your grip and be among those present?

The business sessions and golf will hold the stage on Tuesday, until the evening, at which session will be the addresses of the president, Dr. P. St. L. Moncure of Norfolk, and Dr. Wm. D. Haggard of Nashville, Tenn., prominent surgeon and a past president of the American Medical Association. On the following day, Dr. Lloyd W. Ketron of Johns Hopkins University will be the guest speaker, and on Thursday will come the symposium on the Endocrines in Medicine. This means a special feature for each day in addition to the volunteer papers on a wide variety of subjects.

On the social side, the Local Committee has arranged for a "smoker" to follow the Tuesday evening session. Wednesday evening has been left open for alumni, fraternity or special society dinners, so there will be no hurrying and scurrying to get back to scientific sessions. Later, that evening, the Augusta County doctors have arranged a dance for the members and ladies accompanying them. In this connection, pleasant entertainment has also been arranged for the ladies and the doctors are urged to bring their wives and daughters.

The scientific and commercial exhibits will be up to a high standard and should be of interest to all members.

This is our first meeting in Staunton in twelve years, so let's show our appreciation of their hospitality by turning out in large numbers.

Delegates to the Staunton Meeting.

We give below the names of the delegates and alternates whose names have been reported by component societies as their representatives to our Staunton meeting. A few societies have not yet reported but we hope may send their delegates to Staunton with proper credentials. Members of the Council are, of course, automatically members of the House of Delegates.

Delegate	*Society*	*Alternate*
	ACCOMAC	
Dr. John W. Robertson		Dr. W. M. Burwell
	ALBEMARLE	
Dr. J. C. Flippin		Dr. R. T. Ergenbright
Dr. A. D. Hart		Dr. M. L. Rea
	ALEXANDRIA	
Dr. J. A. Gooch		Dr. H. A. Latane
	ALLEGHANY-BATH	
Dr. R. L. Claterbaugh		Dr. Thomas Winn
Dr. M. B. Jarman		Dr. S. P. Hileman
	AMELIA	
Dr. H. C. Rucker		Dr. J. M. Habel
		Dr. J. M. Habel, Jr.
	ARLINGTON	
Dr. J. H. Walton		Dr. R. H. Detwiler
	AUGUSTA	
Dr. Guy Fisher		
Dr. A. F. Robertson, Jr.		
	BEDFORD	
Dr. C. H. Bondurant		Dr. T. P. West
	BOTETOURT	
Dr. W. H. Saunders		Dr. S. F. Driver
	CULPEPER	
Dr. O. K. Burnette		

Delegate	*Society*	*Alternate*
	CUMBERLAND	
Dr. Nash P. Snead		Dr. E. B. Nuckols
	DANVILLE-PITTSYLVANIA	
Dr. P. W. Miles		Dr. I. C. Harrison
	DICKENSON-BUCHANAN	
Dr. R. L. Phipps		Dr. T. C. Sutherland
Dr. P. Q. Daniel		Dr. A. S. Richardson
	ELIZABETH CITY	
Dr. B. E. Hunt		Dr. R. H. Wright, Jr.
	FAIRFAX	
Dr. F. M. Brooks		Dr. W. P. Caton
	FAUQUIER	
Dr. Wade C. Payne		Dr. M. B. Hiden
	FLOYD	
Dr. J. M. Harman		Dr. F. Clyde Bedsaul
	FREDERICKSBURG	
Dr. R. J. Payne		
Dr. L. F. Lee		
Dr. W. A. Harris		
Dr. John E. Cole		
	HALIFAX	
Dr. Geo. A. Stover		Dr. J. D. Hagood
	HANOVER	
Dr. Judson T. Vaughan		Dr. Hawes Campbell, Jr.
	JAMES CITY-NEW KENT	
Dr. J. R. Tucker		Dr. A. M. Sneed
		Dr. T. B. Henderson
		Dr. B. I. Bell
	LEE	
Dr. G. B. Setzler		Dr. C. H. Henderson
		Dr. T. B. Ely
		Dr. J. G. McNiel
	LOUDOUN	
Dr. G. F. Simpson		Dr. H. P. Gibson
	LOUISA	
Dr. H. S. Daniel		
	LYNCHBURG ACADEMY	
Dr. J. Henry Rawlings		Dr. J. R. Gorman
Dr. E. G. Scott		Dr. John Hundley
	MECKLENBURG	
Dr. W. W. Wilkinson		Dr. A. T. Finch, Jr.
	MID-TIDEWATER	
Dr. J. M. Gouldin		
Dr. H. F. Hoskins		
Dr. R. D. Bates		
Dr. M. H. Harris		
Dr. J. W. Smith		
Dr. M. H. Eames		
Dr. R. R. Hoskins		
Dr. Clarence Campbell		
	NANSEMOND	
Dr. C. J. Riddick		Dr. O. R. Yates
	NELSON	
Dr. S. G. Miller		Dr. H. G. Dickie

Delegate	*Society*	*Alternate*
	NORFOLK	
Dr. J. W. Hunter		Dr. J. W. Anderson
Dr. W. B. Martin		Dr. H. G. Ashburn
Dr. Claiborne Willcox		Dr. A. A. Burke
Dr. F. C. Rinker		Dr. B. A. Doggett
Dr. G. H. Carr		Dr. A. B. Hodges
	NORTHAMPTON	
Dr. H. L. Denoon		
	NORTHERN NECK	
Dr. E. R. Moorman		
Dr. R. E. Booker		
Dr. J. H. Hare		
Dr. E. T. Ames		
	NORTHERN VIRGINIA	
Dr. H. H. McGuire		Dr. L. M. Allen
Dr. C. H. Iden		Dr. Frank Tappan
Dr. E. L. Grubbs		Dr. Elizabeth Sherman
Dr. George Long		Dr. F. T. Amiss
Dr. John Snead		Dr. J. G. Brown
Dr. R. W. Stoneburner		Dr. George Crawford
	ORANGE	
Dr. G. R. Elliott		Dr. Lewis Holladay
	PATRICK-HENRY	
Dr. B. A. Hopkins		Dr. W. C. Akers
Dr. A. W. Rucker		Dr. F. B. Teague
	POST-GRADUATE	
Dr. B. H. Knight		Dr. F. E. Steere
Dr. T. S. Jennings		Dr. W. D. Prince
Dr. C. E. Martin		Dr. G. M. Naff
Dr. G. S. Fultz		Dr. H. C. Jones
Dr. J. A. B. Lowry		Dr. J. M. Hurt
Dr. W. C. Harman		Dr. F. N. Mallory
Dr. O. L. Jones		
Dr. H. B. Showalter		
	PRINCE EDWARD	
Dr. Ray A. Moore		Dr. T. G. Hardy
		Dr. Jos. H. Smith
	RICHMOND ACADEMY	
Dr. Emory Hill		Dr. O. B. Darden
Dr. L. T. Stoneburner		Dr. Ernest Trice
Dr. J. F. Geisinger		Dr. Clyde Ross
Dr. Fred Fletcher		Dr. S. A. Anderson, Jr.
Dr. A. I. Dodson		Dr. Thomas Gill
Dr. Kinloch Nelson		Dr. T. B. Washington
Dr. W. H. Higgins		Dr. Angus Nichols, Jr.
Dr. J. Shelton Horsley		Dr. B. R. Tucker
Dr. A. E. Turman		
	ROANOKE ACADEMY	
Dr. F. A. Farmer		Dr. T. D. Armistead
Dr. G. S. Hurt		Dr. C. H. Peterson
Dr. Alvah Stone		Dr. K. D. Graves
	ROCKBRIDGE	
Dr. Reid White		Dr. J. E. Seebert
	ROCKINGHAM	
Dr. N. M. Canter		Dr. C. E. Watson
	RUSSELL	
Dr. S. C. Couch		Dr. W. C. Elliott

Delegate	*Society*	*Alternate*
	SCOTT	
Dr. N. W. Stallard		Dr. W. O. Pollard
	SOUTHAMPTON	
Dr. J. A. Grizzard		Dr. G. H. Quillen
	SOUTHWESTERN	
Dr. P. S. Smith		Dr. N. H. Copenhaver
Dr. G. A. Wright		Dr. J. S. Staley
Dr. C. F. Graham		Dr. A. N. Chaffin
Dr. A. B. Woolwine		Dr. F. T. Hauser
Dr. D. S. Divers		Dr. W. I. Owens
Dr. J. L. Early		Dr. S. H. Nixon
Dr. R. R. Goad		Dr. W. A. Porter
Dr. W. C. Caudill		Dr. E. S. Carr
Dr. W. P. Davis		
	TAZEWELL	
Dr. Rufus Brittain		Dr. J. P. Williams
	WARWICK	
Dr. J. E. Marable		
	WISE	
Dr. F. S. Givens		Dr. T. J. Tudor

Golf Tournament at State Meeting.

Dr. T. R. Rolston of New Hope, Va., who is in charge of golf for members of the Society at our Staunton meeting, advises that a golf tournament will be held at the Stonewall Jackson Tavern on Tuesday, October 13. Players are asked to bring their State or Club handicaps. The tournament will start at 9:30 a. m., but players may start as late as 2:30 p. m.

Alumni Dinner, Medical College of Virginia.

Dr. Lewis E. Jarrett, executive secretary-treasurer of the Alumni Association of the Medical College of Virginia, has asked us to announce that this Association will have a subscription dinner on Wednesday evening, October 14th, during the time of the State Society meeting. This will be at 6:30 p.m. and reservations may be made at the Registration desk. The dinner will be held in the Ball Room of the Stonewall Jackson Hotel and will be followed by an interesting program which will include a moving picture showing the various activities of the College.

The Virginia Urological Association

Will hold its third annual meeting in Staunton, Wednesday, October 14, at the time in the State Society session set aside for special dinners. The meeting will be in the form of a subscription dinner at 6:30 p. m. at Hotel Stonewall Jackson. Following the dinner, a program of case reports and other matters of interest to Virginia urologists will be presented. Officers of the Association are: President, Dr. Joseph F. Geisinger, Richmond; vice-president, Dr. C. J. Devine, Norfolk; and secretary-treasurer, Dr. L. D. Keyser, Roanoke.

Southern Medical Association.

The meeting of this Association follows closely upon our own State meeting and should be of especial interest to Virginia doctors this year, as one of our own members, Dr. Fred M. Hodges of Richmond, is president. The dates for the meeting in Baltimore are November 17th-20th. All sessions will be held in the Fifth Regiment Armory which is convenient for transportation to a large number of the city's hotels. The post-convention trip will be a cruise on Maryland and Virginia waters, visiting places of historical interest in Virginia. A large attendance from Virginia is expected.

American Public Health Association.

The scientific program of its 65th Annual Meeting in New Orleans, October 20th-23rd, was published in the September issue of the *American Journal of Public Health.*

More than 100 separate scientific sessions are listed, engaging upwards of 300 speakers. There are programs broad enough in scope and of sufficient importance to warrant the attendance of the entire Association in general sessions. Advances in Public Health is one such session, and other sessions deal with diphtheria immunization, mental hygiene, mosquito-borne diseases, and professional education. A symposium on syphilis is also featured.

The program includes the meetings of a number of related organizations which regularly choose the same convention site and dates.

An all-expense post-convention tour to Havana via Florida by train, motor and steamer, will be sponsored and all delegates are invited to join the tour.

A copy of the program, including hotel and railroad information, a summary of the post-convention tour, and other details may be obtained from the Association's offices, 50 W. 50th St., New York City.

Married.

Dr. John Wyatt Davis, Jr., Lynchburg, Va., and Miss Clementene Goode, Utica, Ky., August 20th.

Dr. Richard Sterling Herring, Richmond, Va., and Miss Marie Hurd, Chicago, Ill., September 2nd.

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Dr. Edmund Murdaugh Ellerson, Washington, D. C., and Miss Elsie Boyd Tucker, daughter of Dr. and Mrs. Beverley R. Tucker of Richmond, Va. September 26th.

Dr. Louis De Angelis and Miss Mae Carmela Cavalier, both of New Haven, Conn., June 2, at Richmond, Va. Dr. De Angelis is a member of the class of '36, Medical College of Virginia.

Dr. William Hoge Wood, Jr., class of '33, University of Virginia, Department of Medicine, and Miss Anne Cary Moss of Parkersburg, W. Va., September 12th. Dr. Wood is now a resident physician on the staff of the University of Pennsylvania Hospital in Philadelphia.

Dr. Washington Carlyle Winn, class of '35, Medical College of Virginia, now located at Williamston, N. C., and Miss Harriet Irene Nance of Asheville. N. C., August 29th.

Dr. John Newton Bowden, class of '34, University of Virginia, Department of Medicine, now at the U. S. Marine Hospital in Mobile, Ala., and Miss Emily Lassigne, of New Orleans, La., August 19th.

Dr. J. N. Dudley,

For the past year director of Health of Henrico County, with headquarters in Richmond, Va., left the latter part of September for Baltimore, to take up a scholarship for a year at the School of Hygiene and Public Health of the Johns Hopkins University.

American Association for the Study of Neoplastic Diseases.

At the regular September meeting of this Association, held in Washington, D. C., September 17-18, the following Virginia doctors had part in the program: Dr. Wright Clarkson, Petersburg; Dr. J. Shelton Horsley, Richmond; and Dr. S. W. Budd, Richmond.

Dr. Budd is vice-president of the Association and Dr. Clarkson a member of the Council.

Dr. Hugh H. Trout,

Roanoke, Va., has recently been appointed surgeon on the staff of the Virginia Division, Sons of Confederate Veterans.

Dr. D. Lane Elder,

Hopewell, Va., has been elected to his eighth term as Mayor of that city. He has served fourteen of the sixteen years of existence of this office.

Ten Months of Public Health in Northampton County.

Such is the title of the 1935 report of public health in Northampton County, Va., under the direction of Dr. A. B. McCreary. This report shows a great reduction in infant mortality and also improvement along other lines. There were no deaths from typhoid or diphtheria during 1935. There was an outbreak of measles among the colored people and malaria showed quite an increase. Clinics were opened, under the supervision of the Department, for the treatment of syphilis especially among the indigent Negroes. All immunizations were performed by the practicing physician. the Department furnishing the vaccines. Health education was stressed and all channels for the dissemination of information to the public were utilized. A special throat survey was made in all the white schools during May, 1935, and out of 1,005 children examined, 806 were found to have defective tonsils. Physical examinations were also conducted in twenty-two schools. Mental hygiene is being promoted by lectures to special study groups of the P. T. A. A very intensive program is being conducted in order to secure proper sanitation and much has been accomplished in this work.

Medical College of Virginia News.

The ninety-ninth session of the college opened September 14, 1936, with convocation exercises at 12:00 noon at Monumental Church, preceded by academic procession from McGuire Hall. Mr. Eppa Hunton, IV, member of the executive committee of the Board of Visitors, made the convocation address. Others taking part in the program were Dr. W. T. Sanger, president of the college, Mr. L. C. Bird, president of the alumni association, Mr. Lewis T. Stoneburner, president of the student body, Dr. William B. Porter, professor of medicine, Dr. Harry Bear, dean of the school of dentistry, Mr. Wortley F. Rudd, dean of the school of dentistry, Miss Frances Helen Zeigler, dean of the school of nursing, Mr. J. R. McCauley, secretary-treasurer of the college, and Reverend George Ossman, who gave the invocation. While enrollment figures have not been completed, it is expected that more than six hundred and fifty students will be in attendance in the four schools of the institution. Dr. J. C. Elsom, a graduate of the school of medicine in 1886, was introduced to the assembled body.

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Dr. Lewis E. Jarrett, superintendent of the hospital division, will attend the annual meeting of the American Hospital Association in Cleveland, Ohio, September 28 to October 3. Doctor Jarrett will preside over the Section on Construction.

Dr. J. H. Weatherby has been appointed research associate in pharmacology.

Dr. Harvey B. Haag, professor of pharmacology, will leave shortly for the mid-west to make a visit to the various laboratories of the medical schools in that section.

Dr. Wyndham B. Blanton, professor of history of medicine, has been appointed one of the editors of the *Annals of Medical History*.

Dr. Lee E. Sutton, Jr., dean of the school of medicine, attended the Harvard University Tercentenary Celebration, September 16, 17, and 18, representing the college.

Health and Safety Work of the Red Cross.

From the inception of the Red Cross idea in the mind of a young Swiss on the battlefield of Solferino, down through the years, this worldwide volunteer organization has had the cooperation and support of the medical profession.

In expanding its services to include prompt assistance for victims of natural disasters and in promoting health and safety through year-round programs of public health nursing, instruction in first aid, in water life saving and in home hygiene and care of the sick and in its more recent establishment of highway emergency first aid stations, the American Red Cross has been aided by the Nation's foremost medical authorities, without whose counsel and guidance little of lasting worth could have been accomplished.

Through its public health nursing service, the Red Cross brings the visiting nurse to many small towns and rural communities, where the number of physicians and hospital facilities are at a minimum. Not only through her nursing care, but also by her instruction to mothers and girls in the community in health habits and home hygiene does she assist the country doctor to safeguard the health of his widely scattered practice.

All Red Cross services are supported by the annual membership dues of millions of Americans who join each year during the Roll Call, held from Armistice Day to Thanksgiving. EVERYONE IS INVITED TO HAVE A PART IN THE WORK OF THEIR RED CROSS BY ENROLLING IN THEIR LOCAL CHAPTER.

Dr. G. S. Hartley,

Clifton Forge, Va., has been re-elected a member of the School Board of that city for another term.

Dr. C. E Via,

Norfolk, Va., was the principal speaker at the semi-annual meeting of the Virginia Society of Sons of the American Revolution, in Williamsburg, on September 17th.

Dr. J. Hamilton Scherer

Has been appointed a member of the Medical Faculty of the Medical College of Virginia and Director of the laboratories of the Hospital Division. Dr. Scherer, who is a graduate of the University of Virginia, was for several years connected with the Department of Pathology of that institution. For the past two years he has been a member of the Resident Staff of the Hospital Division of the Medical College of Virginia. He will have his offices in Memorial Hospital and will be engaged in the practice of internal medicine with special reference to hematology.

Dr. James C. Repass,

Class of '25, Medical College of Virginia, who has been located for sometime at Lumberport, W. Va., is now serving a year's residency in pediatrics at the Hospital Division of the Medical College of Virginia. While Dr. Repass is in Richmond, his practice is being looked after by Dr. G. W. McCall of the class of '34, Medical College of Virginia.

The State Fracture Committee

Of the American College of Surgeons is anxious to include on the committee all doctors who are interested in fractures and who wish to take part in the discussion and consideration of same. All members of the State Society interested are invited to send their names to Dr. Thomas F. Wheeldon, secretary, 318 West Franklin Street, Richmond, Va.

"Read Your Own Blood Pressure, 10c."

Such was a large sign displayed recently in front of a device at Coney Island. The New York State Department of Education contends that these machines violate the State Medical Practice Act and

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has asked the Supreme Court to order this and other machines of the kind out of existence. Therefore, this money-making scheme has become the center of a legal battle as the maker of the machines has countered by filing an injunction to prevent interference with his business.

Blood pressure reading is argued to be a diagnosis of a physical condition and should only be done by a physician. The person who receives such a reading in a place of amusement is naturally so fidgety that he will show a higher pressure than he normally has.

The W. A. Baum Co., Inc., of New York, manufacturers of blood pressure apparatus, has asked that any such instance as stated above be reported to them as they are vigorously opposed to the misuse of medico-scientific instruments and are doing everything in their power to break up this practice.

"Country Doctors Hold Front Line Trenches."

The *Peninsula Enterprise,* published at Accomac C. H., Va., in celebration of its fifty-fifth anniversary recently, published a most interesting edition, giving the history of the people, homes, organizations, etc., of Accomac and Northampton Counties. As an evidence of the esteem in which their doctors are held, there appears an article captioned "Country Doctors Hold Front Line Trenches." This gives the history of the Accomac County Medical Society by its secretary, Dr. John W. Robertson, and that of the Northampton County Medical Society by Dr. W. Carey Henderson, its secretary. Both societies have live organizations and should be justly proud of the work they have accomplished and of the doctors in their membership who have helped make the medical history of this State.

These records are being filed in the State Society's office and we hope other of the component organizations may add a history of their accomplishments to this file.

Dr. William F. Hatcher,

Who practiced for a time in Bath County, Virginia, recently completed a twenty-one months' ophthalmic residency at the New York Eye and Ear Infirmary of New York City, and is now associated with Dr. A. R. McKinney of Saginaw, Michigan, where his practice is devoted exclusively to ophthalmology.

Dr. Wright Clarkson,

Petersburg, Va., the latter part of September, attended a tumor clinic at the Michael Reese Hospital in Chicago, and from there went to the annual meeting of the American Roentgen Ray Society in Cleveland.

To Direct Health Education.

Dr. I. C. Riggin, State Health Commissioner, announces the appointment of Dr. J. C. Funk to have charge of the educational work of the State Department of Health. This appointment has been made possible by an increased appropriation authorized by the last General Assembly. Dr. Funk comes to Richmond from the U. S. Public Health Service at Washington, and was formerly with the Pennsylvania State Health Department. He has entered upon his duties and will serve as a centralized information officer for the Department.

Dr. Rector Sells LeGarde,

Class of '35, Medical College of Virginia, who served an internship at St. Vincent's Hospital, Erie, Pa., has located at Damacus, Va., where he is associated with Dr. C. M. Clendenen in general practice.

Dr. W. N. McKenzie,

Class of '35, Medical College of Virginia, who later interned at the Norfolk General Hospital, Norfolk, Va., has located at Albemarle, N. C.. for general practice.

Duke Hospital Post-Graduate Course.

Duke Hospital, Durham, N. C., announces a post-graduate course on Diseases of the Heart, Circulation and Kidney similar to the one given last year on Diseases of the Gastro-Intestinal Tract. This is to be held on October 15, 16 and 17 and prominent teachers from the eastern sections of the United States will participate in the program.

Motion Picture Film On Contraception.

A two reel film, entitled Contraceptive Methods and Technique, is available to medical societies, medical students, and allied groups. It is a complete review of the subject of contraception, giving methods, the dangers and causes of failures of many methods, etc. Further information and booking may be obtained from Dr. Marie Pichel Warner, 15 E. Mosholu Parkway, New York, N. Y.

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Dr. C. C. Hatfield,

Recently of Glade Spring, Va., announces that he is now located at North Holston, Va.

Some Changes of Address.

The following Richmond doctors have advised us of their change of address:

Dr. Joseph Bear to 609 Professional Building.

Dr. William W. Rixey to 207 Professional Building.

Dr. William Bickers to 1601 Monument Avenue.

Dr. W. Ambrose McGee to 1601 Monument Avenue.

Bureau of Human Heredity.

This Bureau is trying to collect on as wide a scale as possible material dealing with human genetics. Later this material will be analyzed and information distributed. The Council directing the Bureau has asked for all available material from institutions and individuals, furnishing well-authenticated data on the transmission of human traits whatever these may be. Pedigrees are particularly desired; twin studies and statistical researches are also relevant. Material should be given with all available details in regard to source, diagnostic symptoms and the name and address of the person or persons who vouch for accuracy. All such details will be regarded as strictly confidential. Those desiring further information or wishing to send material may get in touch with the Bureau of Human Heredity at 115 Gower Street, London, W. C. 1, England.

Books Available to Doctors.

Recent acquisitions at the Library of the Medical College of Virginia available to our readers include:

League of Nations—Health organization. Report on the Physiological bases of nutrition by the Technical Committee appointed by the Health Committee. (Meeting held in London, November 25-29, 1935) Geneva, 1935.

Levine, S. A.—Clinical heart disease.

London School of Hygiene and Tropical Medicine—A classification for medical libraries.

Maltz, Maxwell—New faces—new futures; rebuilding character with plastic surgery.

Marshall, F. H. A.—Introduction to sexual physiology.

National Geography Society—The book of wild flowers.

Odum, H. W.—Southern regions of the United States.

Pacini, A. J.—Vitamin E.

Penniman, T. K.—A hundred years of anthropology.

Peters, John P.—Body water—the exchange of fluids in man.

Rogers, W. E.—Tree flowers of forest, park and street.

Ryle, J. A.—The aims and methods of medical science.

Samuels, Saul S.—The diagnosis and treatment of diseases of the peripheral arteries.

Schwartz—Crown and bridge.

Schwartz—Oral anatomy.

Shennan, Theodore—Post-mortems and morbid anatomy.

Survey of Nursing Education in Canada.

Waddington, C. H.—How animals develop.

Webb, Gerald B.—Tuberculosis.

Westaway, F. W.—The endless quest; 3000 years of science.

White, William A.—Twentieth century psychiatry.

Physician Wanted.

We have been advised that a young physician is wanted at Jamesville, Martin County, N. C., as the physician serving this community died recently. This is a sawmill village of four or five hundred people, in a tobacco section of the state, with a good substantial surrounding country. Further information may be secured from Mr. W. W. Walters, of Jamesville.

Nurse-Secretarial Position Wanted

In doctor's office, by graduate nurse. Will accept position in any section of State. References upon request. Address (Miss) Mary Parker, R. N., 721 West Main Street, Richmond, Va., or phone 3-2951. (*Adv.*)

Specialty Salesmen.

We have several territories open for high-grade specialty salesmen now contacting physicians and surgeons with surgical instruments or therapeutic equipment. If you are interested in a steady income from a profitable sideline which does not interfere with your main line, communicate with us for full particulars. The Bley Corp., 2306-10 Wabansia Ave., Chicago. (*Adv.*)

Obituary Record

Dr. Manfred Call,

Widely known diagnostician of Richmond, Va., died in Johns Hopkins Hospital, Baltimore, on September 13th, following an operation from which he was apparently rallying satisfactorily. Dr. Call was a native of Richmond and fifty-nine years of age. He received his professional education at the Medical College of Virginia from which he graduated in 1899 and later studied at Johns Hopkins. He was active in medical circles and had been for

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some years professor of clinical medicine at his Alma Mater. Dr. Call was one of the founders of Stuart Circle Hospital of this city and an active worker in the Richmond Academy of Medicine, and the Medical Society of Virginia and was also affiliated with several other medical organizations. He is survived by his wife and three children, one of them being Dr. Manfred Call, III, of Richmond.

Dr. John W. Scott,

Well-known physician of Gordonsville, Va., died August 25th, after a long illness. A native of Orange County, Va., he was eighty-one years of age and graduated from the College of Physicians and Surgeons, Baltimore, in 1878. After this Dr. Scott began practice, first using horseback, and continued in active work until eight years ago. He was formerly health officer of Gordonsville, president of the Town Council for thirty years, a past master of the Masonic Lodge, and a leader in political, civic and club activities. Dr. Scott had been a member of the Medical Society of Virginia for fifty-eight years. He is survived by two sons and three daughters.

Dr. Savala Eustace Gunn,

Hopewell, Va., died August 26th, after an illness of only two days, death being due to acute pancreatitis. He was a native of Dinwiddie County and forty-four years of age. Dr. Gunn graduated from the Medical College of Virginia in 1926. After serving an internship, Dr. Gunn went to Hopewell where he became plant physician of the Tubize Company. He was a veteran of the World War, having served overseas, and was wounded in 1918. Dr. Gunn had been a member of the Medical Society of Virginia for nine years and was active in medical circles. He was president of the Southside Virginia Medical Association in 1935. His wife and a daughter survive him.

Upon the call of President, the members of the Hopewell Medical Society duly assembled and the following resolutions were presented and adopted:

Whereas, God, in his Infinite Wisdom, has deemed it wise to take from our midst our beloved and efficient co-worker, Dr. S. E. Gunn.

BE IT RESOLVED:

First: That the members of the Medical Society deeply regret and hereby profess our profound sorrow at the untimely death of our friend and colleague.

Second: Whereas, he has faithfully followed the practice of medicine in our community for a number of years, giving himself and his time unstintingly to the poor and needy in their afflictions, we commend his unselfish service to mankind and extend to the bereaved family our heartfelt sympathy in their bereavement.

Third: That a copy of these resolutions be sent to Dr. Gunn's family, the local newspaper, and to the VIRGINIA MEDICAL MONTHLY.

T. E. ARMSTRONG,
F. M. HOWELL,
O. L. JONES,
Committee on Resolutions.

Dr. James Morehead Whitfield,

Richmond, Va., died September 4th, after an illness of several months. He was seventy years of age and received his degree in medicine from the University of Virginia in 1887. Dr. Whitfield had been city coroner for nineteen years and was also widely known as a toxicologist and a chemist, having given up the practice of medicine to devote his time to the study of chemistry. He also taught this branch for sometime at the Medical College of Virginia. Dr. Whitfield is survived by three sons, one of them being Dr. James M. Whitfield, Jr., of Richmond.

Dr. Joseph Wilton Hope,

Hampton, Va., died September 3rd, at the age of seventy-one. He was a graduate of the Medical College of Virginia, class of' 88, and practiced for a time both in Richmond and Poquoson, Va., before locating in Hampton. Dr. Hope was health officer of Elizabeth City County for over a decade, and was also for many years a member of the Medical Society of Virginia, until retirement from active work several years ago.

Dr. James Meschter Anders,

Widely known physician of Philadelphia, died August 29th, at the age of eighty-two. He was a graduate of the University of Pennsylvania, Department of Medicine, in 1877. Dr. Anders had served on the faculty of his Alma Mater for many years and at the time of his death was emeritus professor of medicine. He was a member of many scientific and civic organizations and was the author of several well-known medical books.

Lord Berkeley George Moynihan,

Of Leeds, England, died September 7th, at the age of seventy years. He was known throughout the medical world as surgeon and author.